Whereas the settlers at Jamestown and Plymouth were initially deprived of the fruits of their own labor and therefore lacked the incentive for private initiatives and hard work;

Whereas William Bradford, Governor of the Plymouth Plantation, wrote that in response to the misery and want experienced by the people of Plymouth he decided ''that they should set corn every man for his own particular; and that regard trust to themselves . . . . This had very good success, for it made all hands very industrious, so as much more corn was planted than otherwise would have been by any means the Governor or any other could use.'';

Whereas on November 18, 1618, ''The Great Charter'' endowed the colonists of Virginia with the right to profit from property under their individual control for the first time; and

Whereas the result of the Great Charter was a blossoming of individual initiative and self-sufficiency that laid the foundations for the American tradition of economic freedom, prosperity, and self-government; Now, therefore, be it

Resolved, That the Senate—

(1) commends the men and women of our first colonies who began the American tradition of hard work and individual initiative;

(2) honors all those who have defended the right of individuals to own property, pursue their own initiative, and to reap the fruits of their own labor; and

(3) designates November 18, 1996, as ''American Free Enterprise Day''.

The President is authorized and requested to issue a proclamation calling upon the people of the United States and Federal, State, and local administrators to observe the day with appropriate programs, ceremonies, and activities.

IMPLEMENTING PROVISION OF THE CONGRESSIONAL ACCOUNTABILITY ACT OF 1995

Mr. NICKLES. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of Senate Resolution 304, submitted earlier today by Senator LOTT.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

A resolution (S. Res. 304) approving certain regulations to implement provisions of the Congressional Accountability Act of 1995 relating to labor-management relations with respect to employing offices of the Senate and employees of the Senate, and for other purposes.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the resolution?

There being no objection, the Senate proceeded to consider the resolution.

Mr. NICKLES. Madam President, I ask unanimous consent that the resolution be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the resolution appear at this point in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 304) was agreed to, as follows:

S. RES. 304

Resolved,

SECTION 1. APPROVAL OF REGULATIONS.

(a) IN GENERAL.—The regulations described in subsection (b) are hereby approved, insofar as such regulations apply to employing offices of the Senate and employees of the Senate under the Congressional Accountability Act of 1995 (2 U.S.C. 1301 et seq.) and to the extent such regulations are consistent with the provisions of such Act.

Mr. GRASSLEY. Mr. President, I would like to compliment the Senate and the leadership for acting on these resolutions today approving certain Congressional Accountability Act regulations. The first bill passed in this Congress was the Congressional Accountability Act. With great fanfare we stood together in this Chamber and announced to other Americans that we, as Senators, are no better than they are. We are not special, we are not different, and we will no longer make laws just for other Americans. Rather, we will make laws for all Americans, including ourselves. And with my bill, the Congressional Accountability Act, we applied 11 laws, including the Fair Labor Standards Act, the Americans With Disabilities Act, and so on, to ourselves.

Now the Office of Compliance, created by the Congressional Accountability Act, has promulgated regulations that require our approval. The resolutions before us approve the so-called 220(d) regulations. These regulations address the collective bargaining rights of nonlegislative offices. I am very pleased that the Senate is acting on these regulations today.

Unfortunately, neither of these resolutions contain the 220(e) regulations, which address the collective bargaining rights of legislative offices. The House Oversight Committee recently voted to send these regulations back to the Office of Compliance and asked that they be redrafted. And last week, the Office of Compliance's Board responded with two separate letters addressing the committee's actions. Due to these recent events, it seems pointless to push the Senate to consider these regulations at this time. However, I plan to ask the leadership to make the 220(e) regulations one of the first items of business for the 105th Congress.

If we are to be honest with the American people, we must not escape fully implementing the Congressional Accountability Act. For now, I ask that the Senate act on the 220(d) regulations by voting on these resolutions.

APPROVING CERTAIN REGULATIONS TO IMPLEMENT PROVISIONS OF THE CONGRESSIONAL ACCOUNTABILITY ACT OF 1995

Mr. NICKLES. Madam President, I ask unanimous consent that the Rules Committee be discharged from further consideration of House Concurrent Resolution 207, and the Senate proceed to its immediate consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:

A concurrent resolution (H. Con. Res. 207) approving certain regulations to implement provisions of the Congressional Accountability Act of 1995 relating to labor-management relations with respect to covered employees, other than employees of the House of Representatives and employees of the Senate.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the concurrent resolution.

There being no objection, the Senate proceeded to consider the concurrent resolution.

Mr. NICKLES. Madam President, I ask unanimous consent that the resolution be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the resolution be placed at the appropriate place in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The concurrent resolution (H. Con. Res. 207) was agreed to.

VETERANS' HEALTH CARE ELIGIBILITY REFORM ACT OF 1996

Mr. NICKLES. Madam President, I ask unanimous consent that the Veterans Affairs Committee be discharged from further consideration of H.R. 3118, and that the Senate proceed to its consideration.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The assistant legislative clerk read as follows:.

A bill (H.R. 3118) to amend title 38 of the U.S. Code to reform eligibility for health care provided by the Department of Veterans Affairs.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.

AMENDMENT NO. 5414

(Purpose: To provide a substitute)

Mr. NICKLES. Madam President, Senator SIMPSON has a substitute amendment at the desk. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Oklahoma [Mr. NICKLES], for Mr. SIMPSON, for himself and Mr. ROCKEFELLER, Mrs. HUTCHISON, Mr. AKAKA, Mr. MURKOWSKI, and Mr. WELLSTONE, proposes an amendment numbered 5414.

Mr. NICKLES. Madam President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The text of the amendment is printed in today's RECORD under ''Amendments Submitted.'')

Mr. SIMPSON. Madam President, the legislation now before this body may be one of the most significant veterans' bills of the last few years. In agreeing to this bill, the Congress will make, under the rubric of health care ''eligibility reform'', changes in the nature

of our Nation's health care commitment to veterans that are more far-reaching than any decision since the end of World War II.

The Congress faces the issue of setting priorities for VA care because all 26 million veterans are eligible for VA health care. However, VA care is not an entitlement. VA provides as much care to as many veterans as resources allow.

Our Nation's historic commitment to veterans is to care for the wounds of war, that is, to care for service-connected disabilities. The VA hospital system was created to fulfill that obligation. And, having created a network of hospitals—now numbering 173—it made good sense to put it to use caring for non-service-connected veterans when space was available. That is how VA got into the business of caring for non-service-connected conditions and veterans.

As so often happens, the world changed over time, while VA and the laws that govern VA lagged behind. Over time, the non-service-connected tail began to wag the service-connected dog. Today, 89 percent of VA's medical workload is care for non-service-connected conditions. VA built a hospital system at a time when the terms ''hospital care'' and ''medical care'' were synonymous. Today, American medical care is rapidly moving out of hospitals and into the outpatient arena. VA is also moving in that direction. But, VA's movement has been hampered by statutory ''eligibility'' rules which set priorities reflecting VA's hospital-based infrastructure. VA medical centers are underutilized and VA has excess beds.

This fact is reflected in the eligibility rules which give a large number of veterans, perhaps 10 million, priority access to inpatient hospitalization.

Outpatient care is the bottleneck in the VA system and only a small number of veterans, about 500,000, have guaranteed access to a complete continuum of care. In addition, 2.2 million veterans receive whatever care is needed for their service-connected disabilities, and other veterans have conditional access to outpatient care.

The eligibility rules set by Congress are really a way to ration care by setting priorities. They allow VA to live within its resources.

However, they have two major faults: first, they are very complex. Second, they stand modern medical practice on its head by making it easier to provide inpatient care than outpatient care.

The easy to describe—and from a medical point of view, desirable—fix would be to simply eliminate the distinction between inpatient and outpatient care and direct VA to provide care in the most cost-effective therapeutically appropriate manner.

There are two ways to do this. We could direct VA to provide complete care—including outpatient—to all of the veterans now ''mandatory'' for inpatient care. However, giving new access to outpatient care, including virtually free prescription drugs and prosthetic devices such as hearing aids, to millions of additional veterans could be very expensive.

Or, the Congress could direct VA to provide complete care, but only to the number of veterans who could be served with a budget equal to VA's current funding level. This would make VA's rules simple and allow the most cost-effective care. However, $17.1 billion may not fund a full continuum of care for all of the veterans who are now ''mandatory'' for inpatient care. If the Congress takes this course, we could be accused of ''taking away a veterans' benefit'' from those veterans excluded under the new rules.

There are savings to be realized by moving treatment out of hospitals and into less expensive ambulatory care. However, CBO costed unconstrained bills directing that course as being in the billions of dollars.

As I read the CBO estimates, improved and expanded health care benefits will draw new veteran patients who do not now use VA care and the cost of their care would more than offset the savings of moving some inpatient care into the outpatient arena. For Federal budget purposes, VA health care is ''discretionary'' rather than ''mandatory'' spending. CBO cost estimates show how much it will cost to provide the care which ''eligibility reform'' proposals would authorize. Since VA health care spending is ''discretionary'', this is not a ''pay-go'' cost for which offsets must be found. However, appropriators are bound by a ceiling on discretionary spending and they could fund the ''promised'' care only if they reduced other discretionary programs, unless eligibility reform legislation imposes its own limits on the obligations of the taxpayer to fund VA health care.

VA, the Veterans Service Organizations, (VSO's), and others dispute CBO's analysis. They have stated that if the Congress reforms the rules under which VA operates the resulting efficiencies will pay for, or perhaps even more than pay for, the cost of the additional care. The Veterans' Affairs Committee has taken them at their word. The legislation we now bring before the Senate caps VA medical care spending at $17.250 billion for 1997 and $17.9 billion in 1998. I expect those caps to be extended into the future at a level reflecting any increases in the cost of providing health care and taking into account the declining veteran population.

Current eligibility rules do really stand modern medicine on its head by making it easier to treat a veteran on an inpatient basis than in a non-hospital, outpatient setting. Many advocates for eligibility reform point to the need for changes in the law in order to allow VA the freedom to bring itself up to date. I note, however that VA has informed the Committee that it is moving rapidly to a primary care model for medical care under the current rules. VA's Under-Secretary for Health, Dr. Kenneth Kizer,—one splendid administrator—in a May 10, 1996 letter to the Veterans' Committee's distinguished ranking minority member, Senator ROCKEFELLER, deemphasized sound medicine as a reason for seeking ''eligibility reform''. He instead said that he needs eligibility reform in order to instill respect for the law (asserting that VA clinicians feel they must evade rather than follow statutory criteria), in order to provide a mechanism for him to hold the field management accountable to the taxpayers, and to allow him to design an efficient system of care.

Madam President, these are all worthy and desirable goals. I support them. But they are goals driven by sound public administration, not a crisis. The legislation now before the Senate will allow the able Dr. Kizer to pursue those goals.

This legislation makes some real choices and I expect its enactment to have real consequences.

Current priorities for VA health care favor veterans who are service-connected, or poor, or who are members of special groups (former POW's, World War I, exposed to radiation, agent orange, Persian Gulf).

Changing these priorities requires a Congressional decision as to the Nation's health care obligation to veterans. When care was rationed by hospital bed availability it was easy to set limits. If we move to ambulatory care, constrained only by funding, and do not want to, or can not, create a new entitlement, it will be necessary to set explicit limits on who will be served.

In approving this legislation, the Congress will answer questions as basic as:

First, Should VA care for all disability and illness for service-connected veterans, or just the service-connected conditions? If yes, for all service-connected veterans or just some of them? If just some of them, which ones?

Second, Should VA serve as a social safety net for ''poor'' veterans? If yes, how poor?

Third, Should VA provide the same general medical services as the private sector or should it focus on providing veterans with services not generally available in the private sector (such as long term psychiatric care, or lifetime treatment of spinal cord dysfunction?

Madam President, reform even opens the door to the question of VA's role as a direct care provider. Should VA continue to provide care itself or should it fund private sector care for eligible veterans?

Madam President, I would like to take a moment to describe the eligibility reform provisions of the bill and then discuss how the bill answers the questions this issue puts before the Congress and the implications of some of those answers.

First, and most importantly, the bill eliminates the distinction between inpatient and outpatient care. VA is directed to provide hospital care and

medical services in the most clinically appropriate setting for the veterans it treats. However, and this is important, the fully discretionary nature of eligibility for nursing home care remains unchanged. In addition, VA is required to maintain special programs (such as treatment for spinal cord dysfunction, blind rehabilitation, amputation, and mental illness) at least at the current level. On a per capita basis, these services are expensive to provide and it is not the intent of the Committee to allow VA to reduce them in order to pay for other kinds of routine care. This decision means that VA will be forced to reduce the number of veterans it treats for routine conditions and diseases in order to sustain its effort for the unique services it provides. In many cases, VA is a national leader for these services and, in this regard, VA is truly a national asset.

Second, the legislation does not create an entitlement to health care for veterans. Funding for veterans' health care has always been considered discretionary spending and the benefits provided by this bill are explicitly subject to the availability of appropriations. As I noted earlier, the amount of appropriations authorized is capped at about the current level of effort, $17.25 billion for 1997 and $17.9 billion for 1998.

Third, VA is directed to manage access to its health care system by enrolling veterans according to the following priorities:

First, veterans with service-connected disabilities evaluated 50 percent and greater.

Second, veterans with service-connected disabilities evaluated at 30 percent and 40 percent disabling.

Third, former POW's and veterans with 10 percent and 20 percent service-connected disabilities.

Fourth, catastrophically disabled veterans and veterans in receipt of increased non-service-connected disability pension because they are housebound or in need of the aid and attendance of another person to accomplish the activities of daily life.

Fifth, veterans unable to defray the cost of medical care, as prescribed by VA in regulation.

Sixth, all other veterans in the so-called ''core'' group including veterans of WWI, and veterans with a priority for care based on presumed environmental exposure.

Seventh, all other veterans.

VA will be authorized to establish subdivisions for enrollment within priority groups. 1997 and 1998 will be a transition period with enrollment required for treatment after September 30, 1998. VA will, of course, continue to treat service-connected conditions (and veteran service-connected 50 percent and higher) without regard to enrollment. Other veterans will need to be enrolled if they are to receive VA care and VA will enroll only the number of veterans it will be able to treat with the resources available to it.

Madam President, this bill will change the way VA does business and it has the potential to change the characteristics of the veterans in our States who will have a realistic expectation of receiving VA care. Veterans with non-compensable service-connected disabilities will no longer have an automatic priority for care. However, by giving a high priority for enrollment to all veterans with compensable service-connected disabilities we will create a population of 2.2 million veterans who can expect VA to provide a complete continuum of care, including such services as free or virtually free prescriptions, which are not covered by Medicare. If this expansion of services draws large numbers of these veterans to the VA system, then veterans with a low priority for care, including the low-income veterans who now make up a large proportion of VA's patients, may not receive full care. The alternative to this would have been to give a low priority to veterans with minor service-connected disabilities, but that option was not acceptable to the members negotiating the legislation. This outcome is made more likely by the decision to freeze VA's level of effort in its special, but expensive, services. A possible outcome of this bill will be a VA system that primarily treats service-connected veterans for their non-service-connected conditions and veterans whose disabilities or illnesses make them candidates for treatment in one of VA's specialized programs. Of course, this outcome will not come about if VA and the Veterans Service Organizations are correct and the efficiencies this bill will allow VA to realize are adequate to pay for the additional services provided to veterans newly attracted to the VA system. We will see veterans turned away if the Congressional Budget Office and General Accounting Office are correct and liberalized rules lead to dramatic numbers of new veterans seeking free VA care.

Madam President, I also ask my colleagues to be aware of the effect of the increased VA efficiencies necessary if it is to continue to treat its current low income patients. Because VA's resources will remain constrained, we can expect VA to accelerate the already underway process of reevaluating the desirability of continuing to support underutilized and inefficient ''infrastructure''. In a word, we will see some hospitals closed and mission changes for many others. To his clear credit, VA's Under Secretary for Health, Dr. Ken Kizer, has already made more progress in this direction than any other Under Secretary or Chief Medical Director in my time in Congress. And, I believe he would continue that process with or without this legislation. He deserves our highest praise for that. However, I think it safe to predict that every unpopular decision to close a hospital, or limit or redirect a service, will be attributed to this legislation. Since those changes will be the very changes needed to transform VA from a 1945 system of hospitals into a twenty-first century health care system, we should thank those who often point their fingers in our direction—for giving us the credit. If Veterans' Service Organizations in our States voice complaints about the outcome of this legislation, we should remind them of the old saying about being careful what you ask for because you may get it!

Madam President, this amendment goes beyond reform of the rules governing access to VA medical care, and I will take a few minutes to summarize some of the major provisions for the benefit of my colleagues.

It extends VA's authority to treat Persian Gulf veterans with disabling symptoms, but for which no disease can be diagnosed. It also extends to December 31, 1998 VA's authority to provide health examinations to the families of Persian Gulf veterans. This authority originally ended September 30, 1996, but unless the deadline is extended, delays in putting the program into effect would result in a substantially shorter time frame for VA to provide these exams than was contemplated by the Congress when the authority was originally enacted.

In addition, it extends VA's authority to care for veterans presumed to have been exposed to Agent Orange or radiation, and also takes a necessary step to exclude from that treatment authority those diseases for which there is evidence that exposure is not the cause.

The amendment, authorizes the construction of 18 major construction projects. I am pleased that we have made the turn away from VA's past emphasis on the construction of inpatient hospital facilities and are beginning to expand the proportion of scarce resources allocated to ambulatory care. I urge my successors to reenforce this shift in emphasis as ambulatory care is the bottleneck in the VA system and the ''eligibility reform'' provisions of this bill will bring VA even more veterans seeking care on an ambulatory care basis.

The bill authorizes ambulatory care projects in Honolulu, HI ($43 m), Brockton, MA ($13.5 m); Shreveport, LA ($25 m); Lyons, NJ ($21.1 m); Tomah, WI ($12.7 m); Asheville, NC ($26.3 m); Temple, TX: ($9.8 m); Tucson, AZ ($35.5 m); and Leavenworth, KS ($27.75 m). In addition, it authorizes patient environment improvement projects in Lebanon, PA ($9.5 m); Marion, IL: ($11.5 m); Omaha, Neb. ($7.7 m); Pittsburgh, PA: ($17.4 m); Waco, TX ($26 m); Marion, IN ($17.3 m); Perry Point, MD ($15.1 m); and Salisbury, NC ($18.2 m). It also authorizes correction of seismic deficiencies at Palo Alto, CA ($20.8 m) and leases of outpatient clinics in Allentown, PA ($2.159 m); Beaumont, TX ($1.940 m); Boston, MA ($2.358 m); San Antonio, TX ($2.256 m), (also includes a VBA office); Toledo, OH ($2.223 m); and a parking facility in Cleveland, OH ($1.3 m).

In other construction provisions, the amendment directs VA to submit an

annual report with a 5-year strategic plan showing each of the 22 Veterans Integrated Service Network's (VISN) facility needs and plans for meeting those needs, and a listing of VA's 20 highest priority construction projects with the category, priority score and priority rank for each. Additional information will also be required in the prospectus for each project, especially on projected workload and costs. The threshold separating minor from major construction increased from $3 million to $4 million. The ''grandfathered'' authorization of projects already in the works when the authorization requirement was established will be eliminated. Future construction projects will require an affirmative authorization by the Congress. VA will also be required to give the Congress 30 days notice before obligating more than $500,000 for advance planning.

Eligibility reform will call upon VA to break out of the mold created by its historic dependence on its physical infrastructure. This amendment will assist in that process by expanding the types of providers with which, as well as the types of services for which, VA would be able to enter into sharing agreements. The amendment would also allow VA to use a simplified procedure for complying with Federal procurement processes when contracting with commercial providers.

The amendment would also make permanent VA's authority for CHAMPUS sharing agreements, an authority now expiring September 30, 1996.

The ''notice and wait'' period for VA reorganizations is reduced from 90 to 45 days, 30 of which must occur while Congress is in session.

The bar on VA contracting for patient care (which is now suspended through 1998) is deleted, with a requirement that VA report to Congress in advance of any contracting proposal.

The amendment has significant provisions relating to medical services for women veterans. It would require accreditation of VA mammography programs and require VA to adopt and enforce mammography quality control and quality assurance standards. Since VA is already in compliance with these provisions, their enactment will have the effect of codifying VA's current policy and practice. In addition, VA would be directed to survey its facilities in order to identify privacy deficiencies and to incorporate a correction plan into its construction planning process. VA would also be directed to assess the use, and barriers to use, of VA services by women veterans and to report on its findings, recommendations, and the correctional steps it has taken in response to those findings.

The Readjustment Counseling Service program administered through community based ''Vet Centers'' would be updated. Mandatory counseling eligibility would be limited to combat theater veterans (with nontheater Vietnam-era veterans ''grandfathered'' in if they become Vet Center clients before January 1, 2000). The Advisory Committee on the Readjustment of Veterans would be given statutory recognition. VA would be directed to report to the Congress on the feasibility and desirability of collocating Vet Centers and outpatient clinics or providing some medical services at Vet Centers.

VA would be directed to establish up to five Mental Illness Education Research and Clinical Centers [MIRECCs]. The centers established would be chosen from proposals through a peer review process. They would be located in various geographic regions, at sites linking tertiary care and primarily psychiatric VA Medical Centers [VAMCs]. In addition, the Committee on Care of Severely Chronically Mentally Ill Veterans would be made a statutory committee and VA would be required to forward its reports to the Congress.

VA would be directed to conduct research evaluating the most cost effective and efficient way to provide hospice care to veterans, with a report due to the Congress by April 1, 1998.

VA would be authorized to make construction grants to modify State homes to provide adult day care and to pay per diem to State homes for veterans receiving adult day care.

VAMCs would be allowed a new window of opportunity to create research corporations for the purpose of accepting gifts and grants from the private sector for funding VA medical research. This authority would sunset on December 31, 2000. These corporations would be required to report to Congress on the sources and expenditures of their funds.

The Office of the Under Secretary for Health be required to be staffed so as to ensure that the Under Secretary has the benefit of the expertise and policy guidance of: First, VA's specialized programs (e.g. blind rehabilitation, spinal cord dysfunction, mental illness, etc.) and, second, readjustment counseling. The amendment would also eliminate the current requirement that the Associate Deputy Under Secretary be an MD.

In addition, the amendment would eliminate current ''moonlighting'' restrictions imposed on full time VA health care professionals. The recovery of special pay incentives would be suspended for doctors and dentists while they pursue additional residency training if they return to VA employment. VA would also be given more flexibility in payment arrangements for residents and interns.

And, finally, land transfers at VAMCs Milwaukee and Cheyenne would be approved and the VA Medical Center at Mountain Home, TN, would be named after Congressman JAMES H. QUILLEN. That name change would take effect at the beginning of the 105th Congress or when Congressman QUILLEN ceases to be a Member of Congress.

Madam President, this amendment is a major legislative accomplishment. And, as we all know, such an accomplishment requires hard work on the part of everyone involved. We would not be where we are today without the active and sincere involvement and interest of the distinguished ranking minority member of the Committee on Veterans' Affairs, Senator JAY ROCKEFELLER. In addition to recognizing his hard work and that of the Committee's minority staff director and chief counsel, Jim Gottlieb, I must acknowledge the tireless effort and broad expertise of Bill Brew. Bill Brew took me by the hand and ''showed me the ropes'' when I first came to the Committee on Veterans' Affairs as a junior member of the committee. Now years later, and when I am in the last days of my chairmanship of the committee, I find that Bill is still indispensable to the committee's operations. They don't make many like Bill, and veterans everywhere are very fortunate that he has chosen to put his talent to work on the committee staff.

And then my dear friend, SONNY MONTGOMERY. What a man. The present ranking minority member of the House Committee on Veterans' Affairs. Sometimes it seems to us all that there hasn't been a piece of veterans' legislation that has gone through this body since before the war (and I'll let you decide which war) that didn't carry the fingerprints of that fine and noble gentleman. He is leaving the legislative arena this year. But we shall all remember the unquenchable flame powering his singular focus on the men and women whose uniformed service has kept this Nation free for so long. And he has played an unmatched role in the development and enactment of the amendment now before this body. He is a very dear friend. Chairman BOB STUMP of the House committee takes second place to no one when it comes to veterans' legislation and so it has been in the evolution of this bill. He is steady and courageous and I am proud to be his friend also. I thank him for his constructive role and acknowledge his indispensable efforts to transform the commitment of the Congress to America's veterans into effective and generous benefits and services.

Madam President, I suspect that Congressmen STUMP and MONTGOMERY would be the first to acknowledge their debt to their dedicated staff. Carl Commentator, Kingston Smith and JoAnn Webb of the majority staff, and Pat Ryan and Ralph Ibsen of the minority staff have worked tirelessly to implement the policy direction of their bosses.

And lastly, Tom Harvey, my chief counsel and staff director, and his crew on the Senate Veterans' Committee staff have done yeoman service over the last 2 years. Tom has long been the absolutely indispensable voice of reason to whom I have turned for advice so many times when the topic turned to veterans. And he has ''saved my bacon'' many a time, especially with the Veterans' service organizations. A more loyal, savvy, protective friend I

could never have. For the last 2 years, I have slept less fitfully knowing he is in full charge of the committee staff. Chris Yoder, as a fine professional staff member, has been responsible for health care issues, and has shepherded this amendment from it's origin as a cluster of ideas on a ''to do'' list through the legislative product now before this body. Bill Tuerk, the committee's general counsel, has played an indispensable and strong role in the development of this amendment and has committed more time and energy to its enactment than it is reasonable to ask of someone unless they work for love of country as well as for sustenance. Their efforts were well supported by Deputy Staff Director Dave Balland, Dat Tran, Bill Foster, Stephanie Foster, Dr. Sally Satel, Dennis Doherty, Rosie Ducosin, Linda Reamy, and Dolores Moorehead. All very wonderful people. The Members of this body, as well as America's 26 million veterans, are all deeply indebted to all of them for their consistent hard work and commitment.

Madam President, I urge my colleagues to join me in support of this legislation and I thank the Chair.

I ask unanimous consent that a joint explanatory statement be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

JOINT EXPLANATORY STATEMENT FOR H.R. 3118, THE PROPOSED VETERANS' HEALTH CARE ELIGIBILITY REFORM ACT OF 1996

H.R. 3118, the proposed ''Veterans' Health Care Eligibility Reform Act of 1996'' reflects a compromise agreement that the Senate and House of Representatives Committees on Veterans' Affairs have reached on a number of bills considered in the Senate and House during the 104th Congress, including: a construction authorization bill, ordered reported by the Senate Committee on Veterans' Affairs on July 24, 1996, [hereinafter, Senate Construction Authorization Bill]; an eligibility reform bill, ordered reported by the Senate Committee on Veterans' Affairs on July 24, 1996, [hereinafter, Senate Eligibility Reform Bill]; and a health care bill, ordered reported by the Senate Committee on Veterans' Affairs on July 24, 1996, [hereinafter, Senate Health Care Bill]; H.R. 1384, ordered reported on June 15, 1995, and passed by the House on October 10, 1995; H.R. 3376, ordered reported on May 8, 1996, and passed by the House on June 4, 1996; H.R. 3118, ordered reported on May 8, 1996, and passed by the House on July 30, 1996; and H.R. 3643, ordered reported on June 20, 1996, and passed by the House on July 16, 1996.

The Committees on Veterans' Affairs have prepared the following explanation of H.R. 3118 (hereinafter referred to as ''compromise agreement''). Differences between the provisions contained in the compromise agreement and the related provisions in the bills listed above are noted in this document, except for clerical corrections and conforming changes made necessary by the compromise agreement, and minor drafting, technical, and clarifying changes.

TITLE I—ELIGIBILITY REFORM

ELIGIBILITY FOR CARE

Current law

Provisions of law governing eligibility for VA care, set forth in chapter 17 of title 38 U.S. Code, are complex and are not uniform across levels of care. All veterans are ''eligible'' for hospital care and nursing home care, but ''eligibility'' does not in itself assure access. Existing law draws a broad distinction, for purposes of all levels of care, between two categories. The first is a ''multi-tiered'' cohort (''category A'') of veterans who have been recognized through a series of acts of Congress as having a priority to VA care, including service-connected veterans, those considered unable to defray the expenses of necessary care, and several special-eligibility subgroupings. The second category, which has a lower priority for VA care, encompasses all other veterans who have no special eligibility and whose income exceeds means-test thresholds set in law.

With respect to hospital care, the law states that VA ''shall'' provide needed care to all category A veterans, while VA ''may'' provide those same veterans nursing home care. Eligibility for outpatient care is more fragmented. Only limited groups of veterans are eligible for comprehensive outpatient care. The VA ''shall'' furnish such care to those who are 50% or more service-connected, and ''may'' furnish it to former prisoners of war, World War I veterans, and certain profoundly disabled veterans. Current law imposes specific limitations on certain other veterans. Those not eligible for comprehensive services are limited generally to treatment ''to obviate a need of hospital admission'' or to complete treatment initiated on an inpatient basis. Veterans undergoing treatment based on a need to obviate hospitalization are specifically not eligible to receive prosthetic supplies.

A provision of existing law, which sunsets on December 31, 1996, provides special eligibility for health care services for veterans exposed to toxic or hazardous substances during their service.

9House bills

H.R. 3118: Section 2 would provide that, within appropriations, VA shall provide all needed hospital care and medical services (including preventive health services), and may provide all needed nursing home care to veterans in category A (other than veterans with a non-compensable disability). VA shall ensure that a service-connected veteran is provided all benefits under chapter 17 for which the veteran was eligible prior to enactment of the bill. Section 3 would authorize VA to furnish needed prosthetic items for a veteran otherwise receiving care or services under chapter 17; in addition, it would require VA to develop guidelines applicable to provision of hearing aids and eyeglasses.

Section 4 would establish a new section 1705 which would require that VA manage provision of hospital care and medical services under new section 1710 through a system of annual patient enrollment. Enrollment of veterans is to be managed in accordance with specified priorities in the following order:

Veterans with service-connected disabilities rated 30% or higher;

Former POW's and veterans with service-connected disabilities rated 10% and 20%;

Veterans in receipt of increased pension based on need of aid and attendance or housebound status, and other veterans who are catastrophically disabled (such as the spinal cord injured);

Veterans unable to defray the cost of care; and

All other ''category A'' veterans.

In designing an enrollment system, the Secretary would be authorized to establish additional priorities within the priority groupings and to provide for exceptions to the specified priorities where dictated by compelling medical reasons, but would be required to ensure that the system is managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality.

Section 4 would also establish a new section 1706, applicable to managing the provision of hospital care and medical services, which would:

Require VA, to the extent feasible, to design, establish and manage health care programs so as to promote cost-effective delivery of care in the most clinically appropriate setting;

Authorize VA to contract for hospital care and medical services when VA facilities could not furnish such care economically, and to establish such acquisition policies and procedures as appropriate to provide the needed services; and

Require VA to maintain its capacity to provide for the specialized treatment and rehabilitation needs of disabled veterans so as to afford those veterans reasonable access, and ensure that overall capacity is not reduced below its capacity to provide those services as of the date of enactment of the section.

The bill would also authorize appropriations for the medical care account, for the purposes specified for that account in the most recent VA/HUD appropriations act, including the cost of providing care under the amendments made by section 2, not to exceed $17.25 billion for fiscal year 1997 and not to exceed $17.9 billion for fiscal year 1998.

The bill would also include a detailed report on implementation and operation applicable to sections 2, 3, and 4.

H.R. 3643: Section 1 would extend special eligibility provisions applicable to veterans exposed to toxic or hazardous substances and, with respect to herbicide-and ionizing radiation-exposed veterans, revise such eligibility, as follows:

Extend the special eligibility provision applicable to service in the Persian Gulf until December 31, 1998;

Provide with respect to herbicide-exposed veterans, that VA for a two-year period shall provide care for diseases (1) for which the National Academy of Sciences in a report issued in accordance with section 2 of the Agent Orange Act of 1991 has determined (or subsequently determines) that there is either some evidence of, or insufficient evidence to permit a conclusion as to, an association between occurrence of the disease in humans and exposure to a herbicide agent, and (2) which the Secretary, based on peer-reviewed research published within a specified period after the most recent Academy report, determines there is credible evidence suggestive of such an association;

Limit the treatment of veterans exposed to ionizing radiation to treatment of those diseases listed in 38 USC sec. 1112(c)(2) and those as to which VA determines there is credible evidence of a positive association between disease occurrence and radiation exposure; and

Provide that, as to veterans who received care under the special eligibility provisions being amended, such provisions shall continue in effect for continued care of the disability for which such care was furnished before the date of enactment.

Section 1 would also expand eligibility for health care applicable to the Persian Gulf War to veterans who served in Israel or Turkey during the period August 2, 1990 through July 31, 1991.

Senate health care reform bill

Section 2 would amend section 1701 of title 38 to add definitions for the terms ''health care'' and ''respite care''.

Section 3 generally conditions eligibility for health care to a requirement that a veteran enroll for VA care. It would provide that VA—

Shall furnish health care to any veteran for a service-connected disability, and any veteran who is 50% or more service-connected disabled, a former prisoner of war, or a veteran of World War I or the Mexican border; and shall furnish hospital care for the treatment of any disability of a veteran with a compensable disability;

Shall, to the extent resources and facilities are available, furnish health care to all other category A veterans (other than veterans with a non-compensable disability); and

May furnish health care, subject to copayment requirements, to any other veteran.

The section recodifies existing law on eligibility for nursing home care and domiciliary care, but generally conditions such eligibility on a requirement that a veteran enroll for such care. The section would also recodify into new section 1710, without substantive change, other eligibility provisions of current section 1712.

The section would exempt veterans who are 50% or more service-connected disabled and veterans in need of care for a service-connected condition from the requirement that a veteran enroll to receive VA care, and provide that VA shall automatically enroll such veterans upon application for care.

Section 3 would extend through December 31, 1997, existing law governing special eligibility for veterans exposed to toxic or hazardous substances.

Section 4 would require that VA manage provision of care under new section 1710 through a system of annual patient enrollment, with enrollment of veterans (who are not automatically enrolled) to be managed in accordance with specified priorities in the order listed, from veterans with service-connected disabilities rated 50 percent or greater having the highest priority and category C veterans the lowest. In designing an enrollment system, the Secretary would be authorized to establish additional priorities within the priority groupings, and to provide for exceptions to the specified priorities where dictated by compelling medical reasons.

Section 5 would make conforming and clerical amendments.

Section 6 would authorize appropriations for the Department for FY 1997 of $17,068,447,000 for the purposes of the provision of VA medical care. It would authorize increases in appropriations in subsequent fiscal years in the amount of the consumer price index.

Compromise agreement

Sections 101, 103, 104, 105, and 106 are derived substantially from H.R. 3118, with revisions, based primarily on the Senate bill, to include the following:

Addition of a requirement that, effective on October 1, 1998, VA may not provide hospital care or medical services unless the veteran enrolls with VA;

Revision in the list of priorities for enrollment to provide highest priority to any veteran who has a service-connected disability rated 50% or greater, and second priority to veterans 30% or 40% service-connected disabled:

Deletion of proposed amendments to section 1703 of title 38 that would have established broad authority to contract for hospital care and medical services; and

With respect to the requirement that VA maintain its special disability program capacity, inclusion of a report requirement and establishment of a consultative role for special VA committees in assisting the Secretary in carrying out this provision.

Section 102 would extend special eligibility provisions applicable to veterans exposed to toxic or hazardous substances and, with respect to herbicide- and ionizing radiation-exposed veterans, revise such eligibility. With respect to the special eligibility provisions associated with ionizing radiation and Persian Gulf War service, the section follows section 1 of H.R. 3643 (with the exception of the proposed expansion to Israel and Turkey, which is not contained in the compromise). The revisions applicable to herbicide-exposed veterans are partially derived from H.R. 3643, and would:

Extend the special eligibility provision (applicable to herbicide-exposed veterans) in existing law until December 31, 2002, but provide that VA shall not furnish care (under this special eligibility authority) for diseases for which the National Academy of Sciences, in a report issued in accordance with section 2 of the Agent Orange Act of 1991, has determined that there is evidence that is (at least) suggestive of the lack of a positive association between occurrence of the disease in humans and exposure to a herbicide agent; and

Provide that, as to veterans who received care under the special eligibility provisions being amended (for herbicides and ionizing radiation), such provisions shall remain in effect for continued care of the disability for which treatment was furnished before the date of enactment.

TITLE II—CONSTRUCTION AUTHORIZATION

AUTHORIZATION OF MAJOR MEDICAL FACILITY PROJECTS

Current law

Section 8104(a)(2) of title 38 provides that no funds may be appropriated for any fiscal year, and the Secretary of Veterans Affairs may not obligate or expend funds (other than for advance planning and design), for any major medical facility project unless funds for that project have been specifically authorized by law.

House Bill

Section 101(a) of H.R. 3376 would authorize the Secretary to carry out the following ambulatory care projects: Dallas, TX, $19.9 million; Brockton, MA, $13.5 million; Shreveport, LA, $25 million; Lyons, NJ, $21.1 million; Tomah, WI, $12.7 million; Asheville, NC, $28.8 million; Temple, TX, $9.8 million; and Tucson, AZ, $35.5 million.

Section 101(b) of H.R. 3376 would authorize the Secretary to carry out the following environmental improvement projects: Lebanon, PA, $9.5 million; Marion, IL, $11.5 million; Atlanta, GA, $28.2 million; Battle Creek, MI, $22.9 million; Omaha, NE, $7.7 million; Pittsburgh, PA, $17.4 million; Waco, TX, $26 million; Marion, IN, $17.3 million; Perry Point, MD, $15.1 million; and Salisbury, NC, $18.2 million.

Section 101(c) would authorize the Secretary to carry out the following seismic correction projects: Palo Alto, CA, $36 million; Long Beach, CA, $20.2 million; and San Francisco, CA, $26 million.

Senate construction authorization bill

Section 101 would authorize the Secretary to carry out identical ambulatory care projects except for the following: Projects not authorized: Dallas, TX; Lyons, NJ; and Tucson, AZ. Projects authorized at modified amounts: Shreveport, LA, $25.4 million; Asheville, NC, $28.5 million; and Temple, TX, $9.5 million. Additional projects authorized in the Senate Amendment: Honolulu, HI, $43 million; Wilkes Barre, PA, $42.7 million; and Leavenworth, KS; $27.75 million.

Section 101 would also authorize the Secretary to carry out identical environmental improvement projects except for the following: Atlanta, GA; Battle Creek, MI; and Waco, TX, which are not authorized.

The bill would not authorize the Secretary to carry out any seismic correction projects.

Compromise Agreement

The projects authorized in the Compromise Agreement are derived from both measures. The Senate agrees to the addition of projects at Waco, TX; Lyons, NJ; Tucson, AZ; and scaled-down seismic work at Palo Alto, CA. The House agrees to the addition of ambulatory care projects at Honolulu, HI and Leavenworth, KS. It also contains a modified authorization of $26.3 million for Asheville, NC, and the House recedes from its proposed inclusion of projects at Dallas, TX; Atlanta, GA; Battle Creek, MI; Long Beach, CA; and San Francisco, CA.

AUTHORIZATION OF MAJOR MEDICAL FACILITY LEASES

Current Law

Section 8104(a)(2) of title 38 provides that no funds may be appropriated for any fiscal year, and the Secretary of Veterans Affairs may not obligate or expend funds (other than for advance planning and design), for any major medical facility lease unless funds for that lease have been specifically authorized by law.

House bill

Section 102 of H.R. 3376 would authorize the Secretary to carry out the following leases of satellite outpatient clinics: Allentown, PA, $2.159 million; Beaumont, TX, $1.94 million; Boston, MA, $2.358 million; and Toledo, OH, $2.223 million.

Section 102 of H.R. 3376 would authorize the Secretary to carry out a lease of a parking facility in Cleveland, OH, for $1.3 million.

Section 102 of H.R. 3376 would authorize the Secretary to carry out a lease of a satellite outpatient clinic and a VBA field office in San Antonio, TX, for $2.256 million. Senate Construction Authorization Bill

Section 102 contains the same lease authorizations as the House bill, and would also authorize the lease of an outpatient facility in Ft. Myers, FL.

Compromise agreement

Section 202 follows the House Bill.

AUTHORIZATION OF APPROPRIATIONS

Current law

Section 8104(a)(2) of title 38 provides that no funds may be appropriated for any fiscal year, and the Secretary of Veterans Affairs may not obligate or expend funds (other than for advance planning and design), for any major medical facility project or major medical facility lease, unless funds for that project or lease have been specifically authorized by law.

House bill

Section 103(a) of H.R. 3376 would authorize to be appropriated to the Secretary of Veterans Affairs for fiscal year 1997 (1) $422.3 million for the authorized major medical facility projects; and (2) $12.236 million for the authorized major medical facility leases.

Section 103(b) of H.R. 3376 would limit the authorized projects to be carried out using only (1) specifically authorized major construction funds appropriated for fiscal year 1997; (2) funds appropriated for Construction, Major Projects, for a fiscal year before fiscal year 1997 that remain available for obligation; and (3) funds appropriated for Construction, Major Projects, for fiscal year 1997 for a category of activity not specific to a project.

Senate construction authorization bill

Section 103(a) would authorize to be appropriated to the Secretary of Veterans Affairs for fiscal year 1997 (1) $299.75 million for the authorized major medical facility projects; and (2) $13.972 million for the authorized major medical facility leases.

Section 103(b) is substantively identical to the House provision in section 103(b).

Compromise agreement

Section 203(a) authorizes to be appropriated to the Secretary of Veterans Affairs for fiscal year 1997 and fiscal year 1998 (1) $358.15 million for the authorized major medical facility projects; and (2) $12.236 million for the authorized major medical facility leases.

Section 203(b) follows the House and Senate provisions except that it provides that projects in section 201 are authorized for funding in fiscal years 1997 and 1998.

STRATEGIC PLANNING

Current law

Section 8107(a) of title 38 requires the Secretary to submit to the Senate and House Committees on Veterans' Affairs an annual report detailing VA's five-year medical facility construction plans, to include a list of the VA's highest priority hospital construction projects.

House bill

Section 201 would repeal the report requirement in section 8107(a) and require a broader annual report on long-range health planning. The new annual report would be required to include (a) a strategic plan for provision of care (including provision of services for the specialized treatment and rehabilitative needs of disabled veterans) through networks of VA medical facilities operating within prescribed geographic service delivery areas; (b) a description of how such networks will coordinate their planning efforts; and (c) a profile of each network.

The network profile would be intended to identify (a) the mission of each medical facility, or proposed facility; (b) any planned change in any facility's mission and the rationale for the change; (c) data regarding the population of veterans served by the network and anticipated changes both in demographics and in health-care needs; (d) pertinent data by which to assess the progress made toward achieving relative equivalency in the availability of services per patient in each network; (e) opportunities for providing veterans services through contract arrangements; and (f) five-year construction plans for facilities in each network.

The report would also be required to include information with respect to each VA medical care facility regarding progress toward instituting identified, planned mission changes; implementing managed care; and establishing new services to provide veterans alternatives to institutional care.

The report would also be required to include (a) the 20 most highly ranked major medical construction projects (by category of project) and the relative rank and priority score for each; (b) a description of the specific factors that account for the project's ranking in relation to other projects within the same category; and (c) a description of the reasons for any change in the ranking from the last report.

Senate construction authorization bill

The Senate Bill contains no comparable provision.

Compromise agreement

Section 204 follows the House Bill.

REVISION TO PROSPECTUS REQUIREMENTS

Current law

Section 8104(b) of title 38 requires the Secretary to submit to the Senate and House Committees on Veterans' Affairs a prospectus for any medical facility proposed by the President or the Secretary. The prospectus is required to include a detailed description and a cost estimate of the proposed medical facility.

House bill

Section 202 of H.R. 3376 would expand the requirements of each prospectus under section 8104(b) to include (a) demographic data applicable to the project; (b) current and projected workload and utilization data; (c) current and projected operating costs of the facility; (d) the priority score assigned to the project under VA's prioritization methodology (and if a project is proposed for funding ahead of a higher-scored project, an explanation of the factors underlying that funding decision); and (e) a listing of each alternative to construction of the facility that has been considered.

Senate bill

No comparable provision.

Compromise agreement

Section 205 follows the House bill.

CONSTRUCTION AUTHORIZATION REQUIREMENTS

Current law

Under section 8104(a)(3)(A) of title 38, the term ''major medical facility project'' means a project for the construction, alteration or acquisition of a medical facility involving a total expenditure of more than $3 million, but such term does not include an acquisition by exchange.

Under section 301(b) of the Veterans' Medical Programs Amendments of 1992, Public Law 102–405, major medical construction projects for which funds were appropriated prior to Public Law 102–405 are exempted from the requirement of congressional authorization.

There is no provision in current law expressly requiring the Secretary to report to the Senate and House Committees on Veterans' Affairs prior to obligating funds from the Advance Planning Fund (APF) or toward design or development of a major medical facility project.

House bill

Section 203(a) would increase the funding threshold for major medical facility projects from $3 million to $5 million.

Section 203(b) would provide that, effective as to fiscal year 1998, the ''grandfather clause'' in section 301(b) of Public Law 102–405 shall have no application.

Section 203(c) would require the Secretary to report in advance on plans to obligate APF funds in excess of $500,000 on any project.

Senate construction authorization bill

The Senate bill contains no comparable provisions.

Compromise agreement

Section 206(a) increases the funding threshold for major medical facility projects from $3 million to $4 million.

Section 206(b) follows the House bill.

Section 206(c) follows the House bill.

TERMINOLOGY CHANGES

Compromise agreement

Section 207 would make technical changes in terminology in sections 8101 and 8109 of title 38 regarding elements of the construction process.

TITLE III—HEALTH CARE AND ADMINISTRATION

Subtitle A—Health Care Sharing and Administration

REVISION OF AUTHORITY TO SHARE MEDICAL FACILITIES, EQUIPMENT AND INFORMATION

Current law

Subchapter IV of chapter 81 of title 38 authorizes VA to enter into agreements with specified health care entities for the mutual use or exchange of use of ''specialized medical resources,'' a narrowly defined term. VA is only authorized to enter into ''sharing agreements'' involving specialized medical resources with health care facilities, research centers or medical schools. VA has broader authority under section 8153 to ''share'' any health care resource only with State veterans homes.

House bill

Section 6 of H.R. 3118 would (a) expand both the range of health care resources which can be the subject of mutual use or exchange of use contracts, and the kind of entities with which VA may so contract; (b) provide that VA may execute such contracts involving any health care resource, and may contract with any individual or entity, including a health plan; (c) provide greater flexibility as to when a VA facility may enter into such a contract, and what payment requirements it may negotiate in selling services, while conditioning the circumstances under which VA furnishes services to non-veterans [only when such an arrangement (1) would not result in delay or denying veterans' care and (2) would result in improving the care of veterans, or is necessary to maintain an acceptable level or quality of service at that facility]; and (d) clarify that VA is to be reimbursed when it provides services under a ''sharing agreement'' to a Medicare-covered patient.

Senate health care bill

Section 101 of S. 1359 contains provisions substantively similar to the provisions described in (a) and (b) of the House bill.

The Senate bill contains no provisions pertaining to the provisions described in (c) and (d) of the House bill

Compromise agreement

Section 301 is derived from provisions of both the House and Senate bills. As provided for under the Senate bill, the section would revise the statement of purpose in 38 USC sec. 8151 to reflect a broader sharing mandate, and revise the definitional provisions applicable to the broader scope of the new authority. Amendments to section 8153 are primarily derived from the House bill and are intended to encourage increased efficiencies, applicable to sharing hospital care and medical services (as those terms are defined in chapter 17 of title 38), supplies, and any other health-care service, support, or administrative resource. The measure is subject to the limitation that VA may furnish services to non-veterans under this section only if veterans will receive priority under such an arrangement and that arrangement either is needed to maintain an acceptable level and quality of service or will result in improved services to eligible veterans. Section 301 would also provide that in instances where the health-care resource is a commercial service, the use of medical equipment or space, or research, and is to be acquired from an institution affiliated with the VA, including medical practice groups, blood banks, organ banks or research centers, the acquisition may be accomplished on a sole source basis. Where the health care resource is to be obtained from other commercial sources, it would be obtained in accordance with simplified procurement procedures developed by the Secretary that would permit all responsible sources to compete for the resources being obtained.

IMPROVED EFFICIENCY IN HEALTH CARE RESOURCE MANAGEMENT

Current law

Title II of Public Law 102–585 authorized an expansion of the cooperative arrangements between VA and DoD facilities instituted

under Public Law 97–174. Public Law 102–585 authorized the Departments to enter into agreements under which VA facilities could provide medical services to beneficiaries of DoD's CHAMPUS program. Under this authority, VA has begun to provide care to dependents of active-duty members and retirees. Section 204 of Public Law 102–585 ''sunsets'' this expanded authority on September 30, 1996.

House bill

Section 5 of H.R. 3118 would repeal section 204 of Public Law 102–585 and extend indefinitely VA's authority to provide care and services through contract arrangements to DoD beneficiaries under chapter 55 of title 10, United States Code. Section 5 would also clarify VA's authority to recover or collect from the insurance plans (including so-called ''CHAMPUS supplemental'' plans) of CHAMPUS beneficiaries cared for by VA to the same extent as DoD recovers for care rendered to these beneficiaries in its facilities. This section would also direct that all funds received by VA from insurance plans of CHAMPUS beneficiaries be credited to the VA facility that furnished the care.

Senate health care bill

Section 212 of S. 1359 would extend for two years, from October 1, 1996 to December 31, 1998, VA's authority to provide care and service through contract arrangements to DoD beneficiaries.

The Senate Amendment contains no comparable provision relating to VA's authority to recover from insurance plans of CHAMPUS beneficiaries or to VA's authority to credit the VA facility that furnished such care.

Compromise agreement

Section 302 follows the House bill. It also provides that any services provided under agreements entered into under section 201 of Public Law 102–585 during the period beginning on October 1, 1996, and ending on the date of enactment of the Act are ratified.

PERSONNEL FURNISHING SHARED RESOURCES

Current law

Section 712 of title 38 established a requirement for minimum numbers of employees in the Department of Veterans Affairs. As implemented, however, this provision has resulted in the establishment of employment ceilings. Such ceilings potentially create a dilemma with respect to medical facility staffing in that they may force a choice between dedicating staff solely to internal service delivery, regardless of the level of efficiency of such service, or to providing as well some level of service delivery to other entities under the auspices of efficiency-driven ''sharing agreements''. Faced with such a choice, facility directors might opt not to embark on any new ''sharing agreements'' or may question the merits of maintaining those in place.

House bill

Section 7 of H.R. 3118 would provide that for purposes of determining the minimum number of positions to be maintained at VA during a fiscal year, the number of positions at VA in any fiscal year (to be reduced under existing law by reference to specified categories of positions) would be further reduced by the number of positions in that fiscal year held by persons involved in providing health care resources under ''sharing agreements'' executed under section 8111 of title 38 (as expanded by section 201 of Public Law 102–585) or section 8153 of title 38.

Senate health care bill

The Senate bill contains no comparable provision.

Compromise agreement

The Compromise Agreement follows the House Bill.

WAITING PERIOD FOR ADMINISTRATIVE REORGANIZATIONS

Current law

Section 510 of title 38 authorizes the Secretary to reorganize the functions of the Administrations, offices, facilities or activities in VA. Prior to implementing such a reorganization, the Secretary must submit to the House and Senate Committees on Veterans' Affairs a report containing a detailed plan and justification for the change. The reorganization may not be started until 90 days after the Congressional committees have received the Secretary's report.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

Section 102 would change the waiting period from 90 days to 45 days, thirty days of which Congress shall have been in continuous session.

Compromise agreement

Section 304 follows the Senate Health Care Bill.

REPEAL OF LIMITATIONS ON CONTRACTING OUTPATIENT CARE ACTIVITIES

Current law

Section 8110(c) of title 38 prohibits contracting out of direct patient care activities or activities ''incident to'' direct care, and permits contracting out other activities at VA health-care facilities only on the basis of a VA-conducted cost-comparison study carried out in accordance with the provisions of that subsection. Under section 1103 of Public Law 103–446, the provisions of section 8110(c) have no effect through fiscal year 1999.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

Section 103 would repeal section 8110(c).

Compromise agreement

Section 305 incorporates the Senate provisions and adds an annual reporting requirement.

Subtitle B—Care of Women Veterans

MAMMOGRAPHY QUALITY STANDARDS

Current law

Section 354 of the Public Health Service Act, as added by Public Law 102–539, relates to the certification by the Secretary of Health and Human Services of facilities which perform mammograms. This section does not apply to VA health care facilities.

House bill

Section 8 of H.R. 3643 would add a new section 7319 to title 38 which would (a) require VA facilities to be accredited by a private nonprofit organization to perform mammography testing; (b) require VA to prescribe quality assurance standards for the performance and interpretation of mammograms and the use of mammography equipment by facilities, that these standards be prescribed by the Secretary of Veterans Affairs in consultation with the Secretary of Health and Human Services, and that they are to be as stringent as those prescribed under the Public Health Services Act; (c) provide for annual inspection of equipment and facilities used by and in Department health care facilities for the performance of mammograms; (d) require that any outside facility performing mammography services for VA under contract must meet the requirements issued by the Secretary of Health and Human Services. Section 8 would also require the Secretary of Veterans Affairs to prescribe standards under section 7319(b) not later than 120 days after enactment. It would also require an implementation report to be submitted to the House and Senate Committees on Veterans' Affairs within 120 days after the Secretary prescribes quality standards or the date of enactment, whichever comes later.

Senate health care bill

Title V contains substantially similar provisions.

Compromise agreement

Section 321 contains this provision.

PATIENT PRIVACY FOR WOMEN PATIENTS

Current law

There is no express provision in current law relating to patient privacy issues for women patients.

House bill

Section 9 of H.R. 3643 would require VA to (a) survey each of its medical centers to identify deficiencies relating to the personal privacy of women patients; (b) ensure that plans to correct deficiencies identified in the survey are developed and incorporated into VA's construction planning processes and given high priority; (c) compile an annual inventory of those deficiencies and remedial plans; and (d) report to Congress annually through 1999 on such deficiencies and include the inventory compiled by the Secretary, the proposed corrective plans and the status of such plans in the report.

Senate health care bill

The Senate bill contains no comparable provisions.

Compromise agreement

Section 322 generally follows the House Bill. The Compromise Agreement limits the construction requirement to projects where it is cost efficient to do so.

ASSESSMENT OF USE BY WOMEN VETERANS OF VA HEALTH SERVICES

Current law

Section 318 of title 38 provides for a Center for Women Veterans at VA. The Center's director serves as the principal adviser to the Secretary on the adoption and implementation of policies and programs affecting women veterans. The Secretary includes in documents submitted to Congress in support of the President's budget for each fiscal year the following: (1) detailed information on the budget for the Center; (2) the Secretary's opinion as to whether the resources proposed in the budget are adequate for the Center; and (3) a report on the activities of the Center for the preceding fiscal year.

House bill

Section 7 of H.R. 3643 would (a) require the Center for Women Veterans, in consultation with the Advisory Committee on Women Veterans, to assess the use by women veterans of VA health services, including counseling for sexual trauma and mental health services; (b) require the Center to submit to the Under Secretary for Health a report by April 1, 1997, 1998 and 1999 on the extent to which women veterans eligible for VA health care fail to seek or face barriers in seeking health services at VA and recommendations for encouraging greater use of such services; (c) require the Secretary to submit a report to the House and Senate Committees on Veterans' Affairs by July 1, 1997, 1998, and 1999 containing the most recent report of the Center, the views of the Under Secretary for Health on the Center's report findings and recommendations, and a description of the steps being taken by the Secretary to remedy any problems described in the report.

Senate health care bill

The Senate bill contains no comparable provision.

Compromise agreement

Section 323 follows the House bill.

REPORTING REQUIREMENTS

Current law

Section 107 of Public Law 102–585, which expired in 1995, required the Secretary to submit annual reports on the provision of health care services and the conduct of research relating to women veterans carried out by, or under the jurisdiction of, the Secretary to the Committees on Veterans' Affairs.

House bill

Section 6 of H.R. 3643 would (a) extend through January 1, 1998, the annual reporting requirements of section 107 of Public Law 102–585; and (b) add to the reporting requirements information on the number of inpatient stays and outpatient visits by women veterans and a description of the Secretary's action to foster and encourage research on women veterans.

Senate health care bill

The Senate bill contains no similar provision.

Compromise agreement

Section 324 follows the House bill.

Subtitle C—Readjustment Counseling and Mental Health Care

ELIGIBILITY FOR READJUSTMENT COUNSELING SERVICES

Current law

Section 1712A requires VA to provide, at the request of any eligible veteran, counseling to assist such veteran in readjusting to civilian life. Under current law, eligible veterans include Vietnam-era veterans and in-theater veterans of post-Vietnam hostilities, such as Lebanon, Grenada, Panama and the Persian Gulf.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

Section 202 would make the following changes in current eligibility for readjustment counseling: it would require VA to furnish such counseling to in-theater Vietnam-era veterans; in-theater combat veterans for periods prior to the Vietnam era; and Vietnam-era veterans who seek such counseling before January 1, 2000, or who have been furnished such counseling before that date. It would also authorize VA to furnish such counseling to any other veteran. The measure would require the Secretary to provide bereavement counseling to the surviving parents, spouse and children of certain veterans and grant the Secretary the discretion to provide bereavement counseling to the surviving parents, spouse and children of other certain veterans; and (d) authorize the Secretary to contract for bereavement counseling under this section in the same manner in which it contracts for medical services for veterans with total service-connected disabilities under sections 1712(a)(1)(B) and 1703(a)(2).

Compromise agreement

Section 331 is derived from the Senate Health Care Bill. It modifies existing law as follows: it requires VA to furnish such counseling to in-theater Vietnam-era veterans and Vietnam-era veterans who seek such counseling before January 1, 2000, or who have been furnished such counseling before that date. It also authorizes VA to furnish such counseling to any veteran who had served in a theater of combat operations prior to the Vietnam-era. Section 331 does not contain any provision relating to the provision of, or contracting for, bereavement counseling.

REPORTS RELATING TO VET CENTERS

Current law

Current law contains no specific authorization for VA to provide medical services at Vet Centers.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

Section 204 would require the Secretary to submit to the Senate and House Committees on Veterans' Affairs a report, not later than six months after enactment, on the feasibility and desirability of collocating Vet Centers and VA outpatient clinics as current leases for such centers and clinics expire. Section 205 would require the Secretary to submit to the Senate and House Committees on Veterans' Affairs a report, not later than six months after enactment, on the feasibility and desirability of providing a limited battery of health care services, including ambulatory services and health care screening services, to veterans at VA readjustment counseling centers.

Compromise agreement

Section 332 incorporates the two report provisions of the Senate Amendment and adds language stating that nothing in the section is intended to preclude the Secretary from providing limited health care services at Vet Centers during the period before submission of the reports.

ADVISORY COMMITTEE ON THE READJUSTMENT OF VETERANS

Current law

There is no statutory requirement for VA to establish an Advisory Committee on the Readjustment of Veterans.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

Section 203 would (a) add a new section 545 to title 38, which would establish in VA the Advisory Committee on the Readjustment of Veterans, consisting of 18 members to be appointed by the Secretary; (b) provide that a term of service on the Committee may not exceed 2 years and that the Secretary may reappoint any member for additional terms of service; (c) require the Committee to submit a report to the Secretary, which shall be submitted to Congress, on the programs and activities of VA that relate to the readjustment of veterans to civilian life; and (d) provide that the original members of the Committee shall be the members of the present, administratively established Advisory Committee on the Readjustment of Vietnam and Other War Veterans.

Compromise agreement

Section 333 follows the Senate bill.

CENTERS FOR MENTAL ILLNESS RESEARCH, EDUCATION AND CLINICAL ACTIVITIES

Current law

There is no provision in current law relating to the establishment of centers for mental illness research, education and clinical activities.

House bill

Section 3 of H.R. 3643 would add a new section 7320 to title 38, which would (a) require the Secretary to designate not more than five VA centers of excellence in mental illness research, education and clinical care activities (MIRECCs); (b) require centers to be established and operated collaboratively (through a formal governance structure) by a VA facility (or facilities) with a mission centered on care of the mentally ill and a VA facility in the same geographic area with a mission of providing tertiary medical care; (c) require that no less than 50 percent of the funds for the center for care, research and education shall be provided to the collaborating facility or facilities with a mission centered on care of the mentally ill; (d) require one of the participating facilities to be affiliated with a medical or other school which provides mental illness training, attracts clinicians and investigators with a clear and focused clinical mental health research mission and maintains an advisory committee; (e) require, as a prerequisite to selection of any MIRECC ''center'' that a peer review panel has determined that any such proposed center meets the highest competitive standards of scientific and clinical merit; and (f) require that at least three of the five centers emphasize the development of community-based alternatives to institutional treatment of mental illness.

The purpose of the MIRECCs would be to facilitate the improvement of health care services for veterans suffering from mental illness—especially from conditions which are service-related—and to develop improved models for the furnishing of clinical services. The centers would do this through research, education and training of health personnel and development of improved models of clinical services. The aim is to channel the interests and expertise of VA tertiary medicine to work toward improving mental health care at VA's often unaffiliated psychiatric hospitals and developing improved models of mental health care delivery. Such collaboration in the case of proposed MIRECCs would entail establishing a dual-sited (or even multi-sited) ''center'' which involves the two (or more) VA institutions forming a collaborative program encompassing mental health research, education and clinical care.

Section 3 would authorize appropriations for centers through 2001, and require annual reports to the Senate and House Committees on Veterans' Affairs not later than February 1, 1998, 1999, and 2000. Section 3 would also require the Secretary to designate at least one center not later than January 1, 1998.

Senate health care bill

Section 301 contains a similar provision, differing primarily in that it imposes no requirement for collaborative operation and establishment of a MIRECC by two or more VA facilities. It would authorize appropriations for centers through 2000, require designation of at least one MIRECC by January 1, 1997, and require annual reporting until 1999.

Compromise agreement

Section 334 generally follows the House bill.

COMMITTEE ON CARE OF SEVERELY CHRONICALLY MENTALLY ILL VETERANS

Current law

There is no provision in current law relating to the establishment of an Advisory Committee on Severely Chronically Mentally Ill Veterans.

House bill

Section 2 of H.R. 3643 would (a) require VA to establish a Committee on Care of Severely Chronically Mentally Ill Veterans to assess VA's capability to meet the treatment needs of veterans, including women veterans, with severe and chronic mental illness; (b) require that Committee members be VA employees with expertise in the care of the chronically mentally ill; (c) require the Committee to advise and make recommendations to the Under Secretary for Health regarding policies for the care of chronically mentally ill veterans; and (d) require the Secretary to submit to the Senate and House Committees on Veterans' Affairs annual reports on the

recommendations of the committee on VA's need for improving care for the chronically mentally ill. The first report would be due not later than April 1, 1997, and subsequent annual reports would be due not later than February 1, 1998, 1999, 2000, and 2001.

Senate health care bill

Section 214 would require the Secretary, not later than 60 days after receipt, to submit to the Senate and House Committees on Veterans' Affairs any report submitted to the Under Secretary for Health by the Special Committee for the Seriously Mentally Ill Veteran as in existence on July 1, 1996.

Compromise agreement

Section 335 follows the House bill.

HOSPICE CARE STUDY

Current law

Current law provides no express authority relating to VA's provision of hospice care to terminally ill veterans. However, many VAMCs currently provide hospice or palliative care in some form, including: (a) on-site hospice care consultation teams; (b) caregiver counseling; (c) the provision of pain management and other services to terminally ill veterans; and (d) inpatient hospice care units, freestanding buildings or separate units where a home like atmosphere is created.

House Bill

The House bill contains no provision relating to this matter.

Senate health care bill

Title IV of S. 1359 would add a new subchapter VII to chapter 17 of title 38, ''Hospice Care Pilot Program; Hospice Care Services''. Title IV would require VA to conduct a five-year pilot program from October 1, 1996, to December 31, 2001, to assess the desirability of furnishing hospice care services and to evaluate the best way to provide hospice care.

VA would be required to set up demonstration projects at 15 to 30 VA sites (selected in a manner that provides a broad spectrum of experience with regard to facility size, location and range of affiliations) at which terminally ill veterans receive care by (a) a hospice operated by a VAMC; (b) a non-VA hospice under contract with a VAMC pursuant to which any necessary inpatient care would be furnished at VA facilities; or (c) a non-VA hospice under contract with a VAMC with any necessary inpatient care to be furnished at non-VA facilities. As to each such program model, VA is to furnish care under the pilot in at least five VAMCs.

The bill would require that in contracting for hospice care, VA would follow the Medicare policy in setting reimbursement rates. Contract hospice rates would generally be capped at the Medicare rates. However, exceptions could be made in cases in which the Secretary determines that the Medicare rate would not compensate a non-VA hospice for providing a veteran with necessary care. The intended effect of this provision would be to ensure that veterans for whom care is extraordinarily expensive due to the nature of their condition would not be excluded from the program.

VA would also be required to include at least 10 VAMCs that offer palliative care to terminally ill veterans. As part of the evaluation, the comparison group would be intended to help the Committee determine whether furnishing a less comprehensive range of services constitutes a viable alternative to VAMCs in which the numbers of veterans desiring such services may not be sufficient to justify a full-scale hospice program.

Not later than August 1, 2000, VA would be required to submit to the Senate and House Committees on Veterans' Affairs a detailed report containing an evaluation and assessment by the Under Secretary for Health of the hospice care pilot program and the furnishing of hospice care services.

In order to ensure that VA patient care is not compromised by this pilot program, the bill would expressly provide that VA would not be precluded from furnishing hospice care services at VAMCs not participating in the pilot program or the comparison group.

The bill would authorize appropriations of $1.2 million for fiscal year 1997, $2.5 million for fiscal year 1998, $2.2 million for fiscal year 1999 and $100,000 for fiscal year 2000.

Compromise agreement

Section 341 would (a) require the Secretary to conduct a research and evaluation study to determine the desirability of furnishing hospice care to terminally ill veterans at VA facilities and to evaluate the most cost effective and efficient way to do so; (b) require the Secretary to conduct the study using VA resources and personnel; and (c) require the Secretary to submit to the Senate and House Veterans' Affairs Committees a report on the research study not later than April 1, 1998. The Committees intend that such study would be conducted by the Management Decision and Research Center of the Health Services Research and Development Service.

PAYMENT TO STATES OF PER DIEM FOR VETERANS RECEIVING ADULT DAY HEALTH CARE

Current law

There is no authority in current law for VA to make per diem payments to State Veterans Homes in connection with the furnishing of adult day health care. There is no authority in current law relating to VA's program of assistance to States in connection with the construction of facilities to furnish care to veterans to provide assistance in connection with the construction of facilities to furnish adult day health care.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

Section 211 would (a) amend section 1741 to authorize VA to provide per diem payments to State Veterans Homes, at a rate set by VA, for adult day health care; and (b) amend subchapter III of chapter 81 to authorize construction grant support to States for expansion, remodeling or alteration of existing buildings to permit the provision of adult day health care.

Compromise agreement

Section 342 follows the Senate Health Care Bill.

RESEARCH CORPORATION

Current law

Subchapter IV of chapter 73 previously authorized VA to establish nonprofit corporations at individual VA medical centers in order to facilitate and foster the conduct of VA medical research. The establishment of such corporations was intended to create mechanisms which could accept public and private grants and administer funds for support of VA-approved research. These corporations have served as flexible mechanisms to enable VA clinicians to carry out research projects for which funding might not be available through VA's own research appropriation. The more than 80 corporations are self sustaining and require no appropriation. VA's authority to establish additional research corporations expired in 1992. Consequently, a significant number of VA facilities, including several major VA medical centers, do not have a research corporation to support their research programs.

House bill

Section 304 of H.R. 3376 would renew VA's authority to establish additional research corporations and extend that authority until December 31, 2000.

Senate health care bill

Section 302 contains a substantially similar provision. It would also make a technical change in citations to the tax code to clarify that research corporations shall be tax-exempt entities without regard to the specific provision of the code under which they achieve that status. It would also expand the annual reporting requirements applicable to the corporations to require the Secretary to report to the Committees with respect to each corporation on amounts received from governmental entities, tax-exempt entities, and all other sources; information on the source of contributions in the case of amounts greater than $25,000 received from entities other than governmental or tax-exempt sources; and with respect to expenditures, amounts expended for salary for research and support staff, for direct support of research, and with respect to expenditures exceeding $10,000, information that identifies the recipient of such payment.

Compromise agreement

Section 343 is generally derived from the Senate bill. It would renew VA's authority to establish additional research corporations and extend that authority through December 31, 2000; delete references to ''section 501(c)(3)'' of the tax code in sections 7361 and 7363 of title 38, United States Code. It would expand reporting requirements, generally as provided for in the Senate bill except (to conform more closely with reporting requirements set by the Internal Revenue Service) that it omits any requirement to isolate amounts received from tax-exempt entities, and requires identification with respect to payees only where the amount expended exceeds $35,000. The provision would also clarify section 7366(b) by specifying that corporations must obtain an audit performed by an independent auditor. In the case of a corporation with annual revenue greater than $300,000, the corporation shall be audited annually. In the case of a corporation with annual revenues between $10,000 and $300,000, the measure requires that an audit be conducted at least once every three years. Finally, the compromise includes an amendment to simplify administration of the requirement that corporation directors and employees are aware of and comply with conflict-of-interest laws and regulations.

VETERANS HEALTH ADMINISTRATION HEADQUARTERS

Current law

Subchapter I of chapter 73 of title 38 requires specified clinical service positions in the Veterans Health Administration and the Office of the Under Secretary for Health.

House bill

Section 205 of H.R. 3376 would (a) repeal certain statutory requirements regarding the organization and staffing of the Office of the Under Secretary for Health; (b) authorize the Under Secretary to include such professional and other services as deemed necessary; and (c) ensure that the Office is sufficiently staffed to provide expertise in clinical care disciplines generally as well as in the unique, specialized VA programs such as blind rehabilitation, prosthetics, spinal cord dysfunction, mental illness and geriatrics and long-term care.

Senate health care bill

Section 201 of S. 1359 would provide that the Secretary may not alter or revise the organizational or administrative structure of the Readjustment Counseling Service.

Compromise agreement

Section 344 is derived primarily from the House provision. The Committees recognize,

however, the importance of ensuring that the Under Secretary's office be staffed so as to have a broad range of clinical expertise and, particularly, expertise in VA's special disability programs. Section 344, accordingly, would require that in organizing the Office, the Under Secretary shall ensure that the office is staffed in a manner such that a designated clinician from the appropriate discipline serve as a principal policy adviser with respect to (1) the VA's unique special disability programs; and (2) the VA's readjustment counseling program. With respect to the latter program, it would require that the Under Secretary ensure that a clinician with appropriate expertise is responsible for the management of that program.

The Compromise Agreement does not contain the statutory repeals proposed in the House Bill. That legislation was derived in part from of legislative proposal submitted by the Department of Veterans Affairs, aimed at providing the Under Secretary of Health greater flexibility to manage a modern health care system. The Committees do not disagree with the view underlying that proposal, that current law is unduly prescriptive and that its centralized management model impedes VA's ability to operate most effectively in a dynamic health care environment. The loss of this provision in no way diminishes support of the Under Secretary's efforts to implement a field management structure which advocates decentralization of authority, programmatic accountability, and flexibility in organizational design and management. The failure to include a provision revising sections 7305 and 7306 of title 38, U.S. Code, should not be construed as an expression of agreement that those provisions any longer represent a sound legislative policy.

DISBURSEMENT AGREEMENTS RELATING TO MEDICAL RESIDENTS AND INTERNS

Current law

Section 7406(c) authorizes the use of disbursement agreements which provide pay and other employee benefits to residents and interns who train at VA hospitals. Current law makes no specific provision for such agreements for residents and interns who train at VA outpatient clinics, nursing homes or other Department medical facilities.

House bill

Section 4 of H.R. 3643 would permit disbursement agreements to be arranged for residents and interns who train at any VA health care facility.

Senate health care bill

Section 111 contains an identical provision.

Compromise agreement

Section 345 contains this provision.

AUTHORITY TO SUSPEND SPECIAL PAY AGREEMENTS FOR PHYSICIANS AND DENTISTS WHO ENTER RESIDENCY TRAINING PROGRAMS

Current law

Subchapter III of chapter 74 authorizes ''special pay'' in addition to basic pay to assist in physician recruitment and retention. To receive special pay, a physician must enter into a special pay agreement that carries certain service obligations. Failure to complete that obligation triggers refund liabilities. Under current law, employees incur a refund liability any time they leave voluntarily. A waiver can be granted only when the employee's breach of an agreement is for reasons beyond their control, as provided by section 7432(b)(2) of title 38. A physician or dentist who enters a residency training program is converted to a special appointment category that is excluded from receipt of special pay. Entering a residency training position constitutes a breach of the agreement and triggers the obligation to repay the special pay that the physician or dentist received during that year, thereby imposing adverse financial consequences on those individuals entering residency training programs.

House bill

Section 5 of H.R. 3643 would temporarily suspend the special pay agreement during residency training and allow the return of the physician or dentist to VA employment without incurring a special pay refund obligation.

Senate health care bill

Section 113 contains an identical provision.

Compromise agreement

Section 346 contains this provision.

REMUNERATED OUTSIDE PROFESSIONAL ACTIVITIES BY VETERANS HEALTH ADMINISTRATION PERSONNEL

Current law

Section 7423(b)(1) prohibits full-time title 38 employees from obtaining outside employment which involves assuming responsibility for providing patient care.

House bill

H.R. 1384 would free registered professional nurses, physician assistants, and expanded-duty dental auxiliaries of this restriction on outside employment.

Senate health care bill

Section 112 would eliminate this restriction as to all title 38 employees.

Compromise Agreement

Section 347 follows the Senate bill.

MODIFICATION OF RESTRICTIONS ON REAL PROPERTY, MILWAUKEE COUNTY, WISCONSIN

Current law

The terms of a conveyance of a parcel of land from the VA to Milwaukee County, Wisconsin, as authorized by statute in 1954, provided that such land was to be used for recreational and other purposes, and that if the county were to attempt to transfer title to a third party, title would automatically revert back to VA. Unlike two other adjacent parcels of land previously transferred from VA to the county, the deed of conveyance made no provision for reversion ''at the option of the United States''. Financing requirements associated with planned construction of a baseball stadium on the tract now require a transfer of title to the State. Legislation is clearly needed to enable the county to transfer the 28-acre tract, which would otherwise revert to the United States, to the State of Wisconsin.

VA has advised, with respect to its authority to weigh the option of reversion, that it will not exercise the option in favor of reversion back to the United States so long as the existing statutory restrictions on use are followed. VA has further advised that in the event that legislation is introduced to modify the deed restrictions, the VA would not object to releasing the properties from the restriction against alienation.

House bill

Section 10 of H.R. 3643 would modify VA's reversionary interest in the land which it had previously conveyed to Milwaukee County and authorize VA to execute instruments to permit the County to grant all or part of such land to another party with a condition on such grant that the grantee use the land only for civic and recreational purposes. It would also provide that the conditions under which title to all or any part of the land reverts to the United States are stated so that any such reversion would occur at the option of the United States.

Senate bill

There is no comparable provision in a Senate bill.

Compromise agreement

Section 348 follows the House Bill.

MODIFICATION OF RESTRICTIONS ON REAL PROPERTY, CHEYENNE, WYOMING

Current law

Public Law 89–345 transferred VA-owned land adjacent to the VA Medical and Regional Office Center (VAMROC) in Cheyenne, WY, to the City of Cheyenne for park and recreational use. The instrument of transfer provides that title to the land will automatically revert to VA in the event the land is no longer used for park and recreational purposes.

The First Cheyenne Federal Credit Union in Cheyenne, WY, proposes to build a building on the land previously transferred to the City of Cheyenne for park and recreational use. The City of Cheyenne, and VA, agree that such a transfer would benefit VA, VA employees, and VA beneficiaries. However, the statutory restriction on the use of the land, and the reverter provision in the transfer instrument prevent such a change in land use without authorizing legislation.

House bill

The House had no provision relating to this matter.

Senate construction authorization bill

Section 202 of the Senate bill would authorize VA to modify the conditions under which the land would revert to VA, and thereby authorize the transfer of the land from the City to the First Cheyenne Federal Credit Union for the purpose of constructing a building to house its operations.

Compromise Agreement

Section 349 follows the Senate provision.

EVALUATION OF HEALTH STATUS OF SPOUSES AND CHILDREN OF PERSIAN GULF WAR VETERANS

Current law

Section 107 of the Persian Gulf War Veterans' Benefits Act (Public Law 103–446) requires the Secretary to conduct a study to evaluate the health status of spouses and children of Persian Gulf War veterans. Such study requires VA to arrange for diagnostic testing and medical examinations of such individuals through September 30, 1996.

House bill

The House bill contains no provision relating to this matter.

Senate health care bill

The Senate bill would extend the program from September 30, 1996 to December 31, 1998.

Compromise agreement

The Compromise Agreement contains this provision in section 352(a). Section 352(b) would provide that any testing and examinations conducted for the purposes specified in section 107 of Public Law 103–446 during the period beginning on October 1, 1996, and ending on the date of enactment of the Act are ratified.

REPORT ON HEALTH CARE NEEDS OF VETERANS IN EAST CENTRAL FLORIDA

Current law

Two years ago, Congress appropriated construction funds to convert the former Orlando Naval Training Center Hospital (which was transferred to VA) into a nursing home. VA currently operates an outpatient clinic at that facility, but has not begun construction on the nursing home care unit. Congress appropriated $17.2 million for the design of a 470-bed medical center and 120-bed nursing home in Brevard County, Florida. That project, developed and proposed by VA,

called for 230 psychiatric beds, 60 intermediate care beds, an ambulatory care clinic and a number of surgical and intermediate medicine beds. The Conference Report on the Fiscal Year 1996 VA/HUD Appropriations bill, however, called for allotting that design money, along with $7.8 million in new funds, to design and construct a comprehensive outpatient clinic in Brevard County.

House Bill

Section 104(a) would require the Secretary to report to the Veterans' Affairs Committees not later than 60 days after the date of enactment of this Act, on the health care needs of veterans in east central Florida, and to include in that report the Secretary's views as to the best means of meeting such needs (and particularly their needs for psychiatric and long-term care).

Section 104(b) would limit the Secretary's authority to obligate funds, other than for working drawings, for the conversion of the former Orlando Naval Training Center in Orlando, Florida, to a nursing home care unit until 45 days after the date on which the report required in section 104(a) is submitted.

Senate construction authorization bill

The Senate bill contains no comparable provision.

Compromise agreement

The Committees attach a high priority to meeting the needs of veterans in Florida. With respect to outpatient care, the Committees believe that construction of an outpatient clinic in Brevard County should begin as soon as possible. While the Conference Report on FY 1996 VA/HUD Appropriations addresses Florida veterans' outpatient needs, it makes no provision for meeting inpatient care needs that were to have been addressed by the Brevard project, particularly the lack of long-term psychiatric beds in the State of Florida.

In light of the unresolved questions surrounding inpatient needs, the Committees believe that a reassessment of the health care needs of veterans in east central Florida is needed. Section 351 of the bill would require the Secretary to report to the Committees on how these veterans' needs could best be met. It would specifically require the Secretary to include in that report his views on how those needs could best be met using existing facilities in east central Florida. The Secretary's analysis should also include a reexamination of other uses of the Orlando facility in light of the changing needs of central Florida's veterans population.

RENAMING OF THE VA MEDICAL CENTER IN JOHNSON CITY, TENNESSEE

Current law

The name of the VA medical center in Johnson City, TN, is the Mountain Home Department of Veterans Affairs Medical Center.

House bill

Section 302 of H.R. 3376 would rename the VA medical center the ''James H. Quillen Department of Veterans Affairs Medical Center'' on January 3, 1997.

Senate bill

There was no similar Senate provision.

Compromise agreement

Section 350 generally follows the House bill.

RENAMING OF THE VA NURSING CARE CENTER IN ASPINWALL, PENNSYLVANIA

Current law

The name of the VA nursing home in Aspinwall, PA, is the Aspinwall VA Nursing Care Center.

House bill

Section 303 of H.R. 3376 would rename the nursing home in Aspinwall, PA the ''H. John Heinz, III Department of Veterans Affairs Nursing Care Center.''

Senate bill

There was no similar Senate provision.

Compromise Agreement

The Compromise contains no provision relating to the renaming of the Aspinwall VA Nursing Care Center.

ADDITIONAL MATTERS: WEST LOS ANGELES VAMC

The Department of Veterans Affairs is directed to appropriately preserve for the Department's future needs, the land on the grounds of the West Los Angeles Medical Center bounded on the north by the VA property boundary, on the south by Wilshire Boulevard, on the east by Sepulveda Boulevard, and on the west by Bonsall Street. The Committee supports uses such as the development of an interim park as a memorial to veterans, or such other use as the Secretary may determine to be consistent with needs of the Department. The Committees understand that local community organizations are willing to work with the Department to raise the private funds to develop the land into a Veterans Memorial Park and to maintain the Park until such time as funds may be appropriated to convert the park to other uses consistent with the mission of the Department that the Secretary determines are in the best interest of the United States, such as cemetery expansion. The Secretary is free to use the property for events which provide benefit to veterans until its development into the Veterans' Memorial Park. The Department is directed not to dispose of the property or to use it for commercial development not in furtherance of the mission of the Department.

Mr. ROCKEFELLER. Madam President, as the Ranking Minority Member of the Committee on Veterans' Affairs, I am enormously pleased that the Senate is considering H.R. 3118, a bill that would, among other things, reform current law relating to eligibility for VA health care. I urge my colleagues to give their unanimous support to this measure as it will be amended with a final compromise developed by the two Veterans' Affairs Committees.

Madam President, before I discuss the content of this legislation, I will provide a brief procedural history so that those seeking to understand the background of the measure as it comes before the Senate today will be able to do so.

H.R. 3118, as it will be amended, which I will refer to as the compromise agreement, includes a number of provisions in three titles.

Title I of the bill contains the provisions which revise the law setting forth the criteria for eligibility for VA health care. The provisions in title I are a compromise between H.R. 3118 as passed by the House on July 30, 1996, and an original bill which the Senate Veterans' Affairs Committee ordered reported on July 24 of this year. Unfortunately, the committee was unable to complete and file its report on this legislation prior to today's action, so there is no formal record of our committee's efforts on this vital issue, a result I deeply regret. I will endeavor to provide some background on our committee's efforts later in my statement.

Title II of the compromise agreement addresses VA medical construction matters, including providing authorization for specific projects. These provisions are a compromise between H.R. 3376, passed by the House on June 4, 1996, and an original bill ordered reported by the Senate Veterans' Affairs Committee on July 24. As with the eligibility reform legislation, the committee was not able to complete and file a report on this legislation prior to today's consideration by the Senate, so there is no formal record of our actions.

Title III of the compromise agreement addresses a range of VA health care programs and services, including several that I have been particularly interested in for a number of years. These provisions are a compromise between a number of House bills—H.R. 1384, passed by the House on October 10, 1995; H.R. 3643, passed on July 16, 1996; and H.R. 3118 and H.R. 3376—and a comprehensive Senate bill, S. 1359, as ordered reported by the Senate Veterans' Affairs Committee on July 24. The committee's report on that legislation, which was filed on September 26, describes the various bills which were combined in the bill as reported.

Madam President, because a description of all of the provisions of the compromise agreement are set forth in the explanatory statement which Senator SIMPSON will place in the RECORD, I will just discuss some of the issues which are of particular interest to me. The explanatory statement was developed in cooperation with the House Committee on Veterans' Affairs and that committee's chairman, Rep. STUMP, will insert the same explanatory statement in the RECORD when the House considers this measure.

ELIGIBILITY REFORM

While I supported the Senate committee's action in ordering reported eligibility reform legislation and I support the inclusion of provisions derived from that measure in the compromise agreement, I do so with some significant reluctance. My reluctance is twofold—first, I remain unconvinced that there is a compelling need for this action at this time; and second, it is unclear that the course of action we are pursuing is the most appropriate.

Before discussing these concerns, I will outline briefly the legislative history of this legislation, and most particularly the activity in the Senate Committee on Veterans' Affairs. As I noted earlier, although eligibility reform legislation was ordered reported by our committee on July 24, a report was never filed. I believe it is important to provide some background on our committee's role in this effort.

Madam President, the current drive for eligibility reform legislation—that is, legislation which would amend those provisions of title 38, United States Code, which set forth which veterans are eligible to receive what care from VA—dates back to at least 1985, my first year in the Senate. Late that

year, in the context of reconciliation legislation, both Houses passed legislation which would have amended the then-current law on access to VA care. The differences between those measures were resolved and the final compromise, which set forth a hierarchy of veterans as to whom VA was required to furnish inpatient care, was enacted in title XIX of Public Law 99–272, the Consolidated Omnibus Budget Reconciliation Act of 1985.

That first attempt at setting forth in law exactly which veterans should be guaranteed what care from VA was limited to inpatient care because of significant differences between the House and Senate over the potential impact of providing such a guarantee for outpatient and other care, concerns that have persisted through to this Congress and that, as I will discuss later in my statement, remain largely unresolved. Indeed, there is some suggestion that those concerns cannot be resolved without some specific data-gathering initiative. And while it is not the sort of data-generating undertaking that I would prefer, what we are doing in the pending measure may be the way in which the Congress finally gets the information we need about demand for VA care and VA's ability to meet that demand within currently available resources.

Following the enactment of COBRA, the next step in the effort to modify the law relating to access to VA care came in 1988 with the enactment, in Public Law 100–322, of legislation which set forth those groups of veterans who would be guaranteed certain access to outpatient care. Because of ongoing concerns about the demand for outpatient care and VA's ability to meet that demand in a timely fashion, the universe of veterans described in the law as guaranteed access to outpatient care was smaller than the universe with access to inpatient care and, within that group, only a small portion was guaranteed unlimited access to ambulatory care.

Thus, under the law as it has been in effect since 1988, only a very small percentage of the veteran population—those with service-connected disabilities rated at 50 percent or more disabling, a number less than 470,000 out of a total service-connected population of 2.2 million—have comprehensive access to both VA inpatient and outpatient care. For the rest of the eligible veteran population, the greatest access to care is provided for inpatient care, with access to outpatient care much more restricted.

Since 1988, there have been various efforts to amend the law. Last Congress, under my chairmanship, the committee made significant progress toward that goal. However, our efforts were carried out as part of the national health care reform effort. When that larger effort died, so too did the work of our committee.

This Congress the issue was again before us and a number of events led up to our markup in July to consider eligibility reform legislation.

For example, beginning early in 1995, I worked with the four veterans service organizations that prepare the Independent Budget—AMVETS, Disabled American Veterans, Paralyzed Veterans of America, and Veterans of Foreign Wars—to develop a draft eligibility reform bill based on those groups' testimony before our committee. Senator SIMPSON and I introduced this bill, S. 1563, in February of this year as a ''by request'' bill. In so doing, we both indicated that we were not endorsing the bill but merely making it available for consideration by the committee.

Last September, VA submitted eligibility reform legislation to the Congress which Senator SIMPSON introduced, by request, as S. 1345 on October 18, 1995. Also last September, The American Legion, during its annual legislative presentation, presented its eligibility reform proposal.

Finally, late in the first session, the House Committee on Veterans' Affairs included eligibility reform provisions as part of the legislation which that committee ordered reported to comply with reconciliation. These provisions were very similar to VA's proposal. Although the reconciliation measure passed the House with the eligibility reform provisions included, those provisions were not included in the conference report on that legislation. This session, the House again passed the eligibility reform provisions in H.R. 3118, which passed the House on July 30, 1996.

Against this backdrop of activity and strong expressions of support from VA and the veterans community for committee action on eligibility reform legislation, our committee held two hearings on the issue. The first, on March 20, 1996, heard testimony from the General Accounting Office and a number of veterans organizations. The second, on May 8, 1996, took testimony from VA and the Congressional Budget Office.

Following those hearings and significant work to develop a proposal which could gain the support of the committee, the committee met on July 24 and ordered reported an original measure. It was that measure which became the basis for the compromise agreement which is before the Senate today.

Our committee's action was premised on the position that whatever legislation we endorsed would have to eliminate the complexity and confusion in current law about which veterans would receive what care, but do so in a budget-neutral manner.

To that end, the committee started from an approach similar to that incorporated in the VA and House bills, both of which sought to eliminate differences in the law on eligibility for inpatient and outpatient care and differences among groups of veterans in the access to types of outpatient care. In an attempt to achieve budget neutrality, both of those approaches made access to all care for all groups of veterans ''subject to appropriations,'' a limitation not included in current law. In addition, the House bill included a provision requiring VA to utilize an enrollment system to manage care. However, that provision did not appear to limit care to those veterans who participated in the enrollment system.

The bill our committee ordered reported added three elements to the general format of the VA and House bills. I am pleased to note that provisions derived from two of those changes are included in the compromise agreement, and I regret that the third element is not included.

The first change that our committee incorporated in the bill we ordered reported related to the way in which veterans' access to care is described in the law. As I just noted, both the House bill and the VA proposal use the phrase ''shall, subject to appropriations'' to describe access to care for all veterans. Under current law, the word ''shall,'' with no limitation, is used to describe the access to care of those veterans who are included in what is known as the mandatory or ''category A'' group, and the word ''may'' is used to describe the access of those veterans in what is known as the discretionary category. While there is some disagreement about the full meaning or scope of the word ''shall'' in the context of access to health care, it is important to note that it is not otherwise limited in current law.

The bill ordered reported by the committee did not go as far as the House or VA bills, nor did we insist on maintaining current law. Instead, we took a middle ground. The bill we ordered reported provided that access to VA care for four subsets of the veterans' population—veterans with service-connected disabilities rated at 50 percent or greater for any disability, all veterans with service-connected disabilities seeking care for those disabilities, former prisoners of war, and veterans of the Mexican border period and World War I—would remain as in current law, that is, by using ''shall'' without any limitation. For all others in the mandatory or category A classification, the ''shall, subject to appropriations'' approach of the House and VA bills was used.

The approach adopted by our committee was designed to ensure that those veterans who have the highest claim on VA resources—veterans seeking care for their service-connected conditions and those more seriously disabled veterans for the treatment of any disability, as well as two categories of veterans whose service distinguishes them—receive the care they need, with no reference to any external limitation. As a practical matter, that result should be ensured by other provisions of the legislation relating to priorities for care, but it was my view, shared by others on the committee, that the Congress should not be cutting back on the promise of current

law as to those veterans with the greatest claim on the system.

Unfortunately, Mr. President, this effort to ensure that access to care is not compromised for these veterans for whom the system was established is not reflected in the compromise agreement. Initially, there was agreement that the compromise agreement would follow the Senate bill as to two of the four groups in the Senate bill—the more seriously disabled veterans and for the treatment of service-connected disabilities—and would apply the ''subject to appropriations'' limitation to all other category A veterans.

However, very late in the process of developing the compromise agreement, the Congressional Budget Office, which had previously expressed no concerns about the approach in the Senate bill, suggested that the use of ''shall'' as to these veterans would create an entitlement to care and that, as a result, spending for such purposes would be mandatory spending, rather than discretionary spending as VA health care funding has always been treated. This, of course, raised budget problems for the legislation.

One way to have avoided this problem would have been to drop the ''subject to appropriation'' language and restore the approach found in current law. However, this approach did not enjoy unanimous support from the Members working on the compromise agreement. While I feel very strongly that appearing to cut back on the guarantee for care for these most deserving veterans is not the course we should be following, I realized that my insistence on either the Senate approach or a return to the phrasing of current law could well jeopardize the enactment of this legislation in this legislative session. Thus, I reluctantly agreed to the use of the ''subject to appropriation'' language as to all veterans. As I noted earlier, as a practical matter, these veterans will still be guaranteed first access to VA care as a result of the priority scheme in the compromise agreement.

The second key difference between the bill our committee ordered reported and H.R. 3118 as passed by the House is the requirement that VA establish a rigorous enrollment system, rather than the apparently nonbinding system incorporated in the House bill. Under the approach in the Senate bill, only those who enroll, with certain exceptions, would be able to receive VA care. The purpose of this enrollment requirement is to create a mechanism that will ensure that those who desire VA care will know with some measure of certainty whether they will or will not receive such care within a particular enrollment period, which I anticipate will run for a year.

Madam President, I am pleased that this enrollment provision has been included in the compromise agreement. So as to give VA the opportunity to prepare to implement this enrollment system, the requirement that veterans enroll in order to receive care will not take effect until October 1, 1998. It is my expectation that, in the coming year, VA will begin to implement an enrollment process so as to gain experience with this system, but will not deny care to any veteran because of a failure to have enrolled.

The third difference between the bill our committee ordered reported and the House bill, at least as it was reported by the House Committee on Veterans' Affairs, was the inclusion in the Senate bill of a cap on the fiscal year 1997 appropriations so as to remove any doubt about the budget neutrality of the bill. This limitation is designed to avoid any suggestion that, if new demand for VA care is generated by the changes in access to care, additional appropriations will follow to meet the demand in the absence of specific authorization.

The House bill was amended prior to House passage to include a similar cap, so there is no longer any substantive difference between the bills on this provision.

Madam President, that is a brief outline of our committee's efforts on eligibility reform legislation. I regret that a more complete discussion is not available in a committee report, but I hope this discussion will shed some light on what our committee did and how we reached the final compromise agreement.

Earlier I noted that my support for both the Senate committee's action and the pending final compromise is reluctant, at best. I will turn now to an explanation of my position, not so as to highlight my personal concerns but rather to note what I believe are pitfalls in what we are doing and as to which we must be aware as the eligibility reforms are put in place.

At the outset, I note that I understand the concerns that many have expressed about the existing rules which set forth which veterans are eligible to receive what types of care from VA. The criticism that many raise about the complexity of these rules is certainly justified, as is the position that these eligibility rules do not reflect current trends in how and where health care is furnished.

Madam President, I note one ironic aspect about this current effort to amend the VA eligibility law, namely that, as VA facilities convert to a primary care model under which veterans are assigned to primary care teams which manage how and when care is furnished, there is less and less attention being paid at the facility level to the limitations in the law on who is eligible for specific care. In fact, it might fairly be said that, at least as to those veterans who are already receiving VA care, eligibility reform is already taking place.

In any event, while a case can be made that the current eligibility system is complex and difficult to defend, it has evolved as an appropriate response to demand and resources constraints over time and may have, to the extent it continues to be observed, a couple of advantages.

First, it is a known system, and facilities and veterans across the system understand its implications in any given locale. Changing it, especially if the changes appear to broaden access to care, as the compromise agreement surely does, can easily create false expectations.

The second advantage, related to the first, is that the current eligibility system is working to ration care. Facilities know when to use its restrictions—most especially on access to ambulatory care—to cut back on access so as to stay within budget. Replacing this system with an untested approach that relies on providing VA facilities with an unspecified authority to deny some veterans access to care is difficult to defend as a step forward.

The current system's role in rationing care seems particularly important in this time of fiscal constraint. In past years, when the issue of eligibility for VA care has been debated, there were those who expressed the belief that any increased demand resulting from a change in eligibility would be addressed by increased appropriations. No one appears to hold that view today. Thus, it seems clear that some form of rationing will continue to be needed if the population of those veterans who are eligible for VA care is not adjusted to meet VA's capacity to provide care.

Having said that, however, I note that my concerns about the compromise agreement bill do not stem from a view that the current eligibility rules must remain inviolate. Rather, my reluctance about this legislation is grounded in my belief that the Congress has a more involved role to play in determining the scope of VA health care than is reflected in the bill the Senate ordered reported or in the compromise agreement.

Madam President, throughout our committee's efforts on this legislation, I have held to the premise, on which I think there is general agreement, that whichever veterans are made eligible for VA care should be able to receive all the care they need, of whatever sort, with the possible exception of long-term care, because of the costs of that care. It certainly could be otherwise—that is, certain groups of veterans could be given access only to certain care—but that seems to be directly contrary to the spirit of eligibility reform.

With that as a guiding premise, and my certainty that VA will not receive any significant infusion of resources for health care at any time in the foreseeable future, it has been my view throughout the debate on eligibility reform that we, the Congress, should expressly set forth in law the population of veterans who are to receive comprehensive care from VA so that there would be no need for VA to make rationing decisions at the facility or other management level. However, as

the debate progressed, it became increasingly clear that developing such an approach was highly unlikely, both because we lacked data on which we might base a more comprehensive action and because reaching consensus on the specifics of such an approach was highly improbable.

During the eligibility reform debate, the key questions as to which I have sought answers have been:

First, in crafting legislation to define which veterans are to receive what care from VA, can we guarantee that those who are told they are eligible for care will be able to get that care without extensive delay?

Second, if we assume that we should expand access to outpatient care—and I do—but that there will be no significant increase in VA's medical care appropriation, will the demand for care, and the costs associated with that demand, increase, remain static, or decrease? Who should make the inevitable rationing decisions?

Third, and finally, do we have the necessary information to make informed decisions on these issue?

While I acknowledge that these are difficult questions, without easy solutions, I have been greatly disappointed in the lack of answers that I have received, particularly from VA. While I believe that I have gained some further insight into some of these issues, much remains far from clear.

For example, nothing VA has said has given me any satisfaction that the proposed eligibility reform proposals will help veterans or VA health care professionals answer with certainty the question of which veterans will receive care in a given time period.

Likewise, nothing VA has provided sheds any light on the likely demand for care that will follow from the enactment of this reform package and the almost certain publicity about that will follow which will lead many veterans to believe that they now are eligible for comprehensive care from VA.

However, as I noted earlier, one clear benefit of our action is that there will finally be an opportunity to see what happens when apparent access to VA care is expanded with no concomitant increase in resources. Once eligibility reform actually takes place, there will finally be some hard information on the impact of changing the definition of which veterans receive what care. This, in turn, will finally enable us to develop some understanding of whether those who believe that VA can furnish more care to more veterans within existing resources, or whether, as other believe, that eligibility reform legislation will generate significant new demand for care.

Madam President, during our committee's consideration of eligibility reform we heard some very different views on this issue. Some, including CBO and GAO, believe that amending the law to provide such expanded access to VA care will result in a significant increase in demand, which either would be met through increased funding or, if new funding is not provided, will lead to delays in getting care or outright denial of care which in turn will generate significant unrest in the veteran community. Others believe that there is little, if any, suppressed demand for VA care and therefore do not believe that eligibility reform will result in any significant increased costs. Indeed, some who testified in support of eligibility reform expressed the belief that it is possible that changing the law will result in a net decrease in the cost of VA care because veterans will be able to be treated in the most appropriate setting, rather than being forced into inpatient care because that is the extent of their current eligibility.

At this point, even after our hearings and all the followup actions associated with them, little more than speculation and best guesses support any of these positions.

What is known is that VA has been appropriated just over $17 billion for medical care in fiscal year 1997. It may be that, operating under revised eligibility criteria, the Department will be able to furnish more care to a larger cohort of veterans at that funding level. But, in any event, that will be all the funds that will be available, come what may.

Madam President, I am confident that the two committees and the Congress will be vigilant in our oversight of VA's implementation of this proposal, and, should it prove unsuccessful at matching scarce resources to demand for care, it will be modified in the years ahead.

Madam President, I have a final thought on this issue before I turn to other parts of the bill. During this debate on eligibility reform, VA expressed the view that any eligibility reform legislation should meet six objectives:

First, the eligibility system should be one that both the persons seeking care and those providing the care are able to understand.

Second, the eligibility system should ensure that VA is able to furnish patients the most appropriate care and treatment that is medically needed, cost effectively and in the most appropriate setting.

Third, veterans should retain eligibility for those benefits they are now eligible to receive.

Fourth, VA management should gain the flexibility needed to manage the system effectively.

Fifth, the proposal should be budget neutral.

Sixth, the proposal should not create any new and unnecessary bureaucracy.

Were I to grade the compromise agreement against this list, I'd say the only element that is clearly met is the fifth one—the measure is budget neutral. And while there can be some discussion about some of the others, the one that I think the bill fails to meet most dramatically is the first. Nothing in what we are doing, without a great deal more experience with the new eligibility criteria, will result in a system that can be understood by patients and providers alike.

In fact, I believe that just the opposite is true—we are setting in place a system that no one will be able to predict or, at least in the near future, understand. Since it is clear that whatever changes are to take place must occur with no additional resources, it is a virtual certainty that VA will still need to ration care and to make decisions about how to do that. While this bill may, in time, yield a flexible, streamlined bureaucracy that establishes clear rules about which veterans are to get what care, that result is far from guaranteed. In the early years of this new system, it is far more likely that more resources will have to be dedicated to making decisions about who gets what care, resulting in a confusing, labor-intensive system.

Madam President, despite my misgivings, it is clear that there is widespread support for our action on this issue. I intend to watch very closely as it goes forward and will be prepared to support any amendatory legislation needed as VA moves into this new era.

CONTRACTING AUTHORITY

Madam President, the compromise agreement contains two separate provisions relating to VA's authority to contract for health care services—section 301, which amends subchapter IV of chapter 81 of title 38, relating to VA's authority to share medical resources with non-VA entities; and section 304, which amends section 8110(c) of title 38 relating to VA's authority to contract with outside entities for the conversion of VA activities to private activities. Taken separately, these two provisions both break substantial new ground in terms of giving VA greater latitude to provide services other than through in-house resources. Together, the enactment of these provisions represents a potential sea change in how VA meets its health care mission.

Madam President, I want to be very clear that the enactment of these provisions is meant to give VA managers greater flexibility to operate the VA health care system in the most effective manner available, consistent with meeting the obligation to furnish quality medical care to those veterans who are eligible for VA care and who seek such services and benefits. I intend to monitor very closely VA use of this new flexibility and will not hesitate to seek to reimpose limitations on the Department's contracting authority if it appears that either authority is being used in a manner that impinges on veterans' access to care in the name of fiscal restraint. I invite input from the veterans organizations, veteran patients, VA employees and their representatives, those organizations which represent groups of VA professionals, and others with an interest in the integrity of the VA health care system.

MIRECC'S

Madam President, I am very pleased that a longstanding Senate initiative dating back nearly a decade—the establishment of VA centers of excellence in mental health research—is included in the compromise agreement. The provision in the compromise agreement is derived directly from legislation I originally introduced in S. 425 on February 15, 1995, with the cosponsorship of committee member Senators AKAKA, DORGAN, WELLSTONE, MURKOWSKI, and CAMPBELL.

Madam President, this provision requires VA to establish up to five centers of excellence in the area of mental illness at existing VA health care facilities. These centers, to be known as Mental Illness Research, Education, and Clinical Centers [MIRECC's] will be a vitally important and integral link in VA's efforts in the areas of research, education, and provision of clinical care to veterans suffering from mental illness.

As I noted at the time I introduced S. 425, the need to improve services to mentally ill veterans has been recognized for a number of years. For example, the October 20, 1985, report of the special purposes committee to evaluate the Mental Health and Behavioral Sciences Research Program of the VA, chaired by Dr. Seymour Kety—generally referred to as the Kety Committee—concluded that research on mental illness and training for psychiatrists and other mental health specialists at VA facilities were totally inadequate. The Kety report noted that about 40 percent of VA beds are occupied by veterans who suffer from mental disorders, yet less than 10 percent of VA's research resources are directed toward mental illness.

Little has changed since that report. The percentage of VA patients suffering from mental illness continues to hover over the same 40 percent rate found by the Kety Committee, and little has changed with respect to VA's research on mental illness.

VA provides mental health services to more than one-half to three-quarters of a million veterans each year, yet in the years between the time the Kety Committee began its work and now, there has not been a significant effort to focus VA's resources on the needs of mentally ill veterans. Among the recommendations of the Kety Committee was one that VA centers of excellence be established to develop first-rate psychiatric research programs within VA. Such centers, in the view of the Kety Committee, would provide state-of-the-art treatment, increase innovative basic and clinical research opportunities, and enhance and encourage training and treatment of mental illness.

Based on the recommendations of the Kety Committee, the Committee on Veterans' Affairs began efforts nearly 10 years ago to encourage research into mental illnesses and to establish centers of excellence. For example, on May 20, 1988, Public Law 100–322 was enacted which included a provision to add an express reference to mental illness research in the statutory description of VA's medical research mission which is set forth in section 7303(a)(2) of title 38.

At that time, the committee urged VA to establish three centers of excellence, or MIRECC's, as proposed by the Kety Committee. Unfortunately, VA has done little to implement the recommendations of the Kety Committee.

I also note that the January 1991 final report of the blue ribbon VA Advisory Committee for Health Research Policy recommended the establishment of MIRECC's as a means of increasing opportunities in psychiatric research and encouraging the formulation of new research initiatives in mental health care, as well as maintaining the intellectual environment so important to quality health care. The report stated that these ''centers could provide a way to deal with the emerging priorities in the VA and the Nation at large.''

In light of VA's failure to act administratively to establish these centers of excellence, our committee has developed legislation to accomplish this objective. The proposed MIRECCs legislation is patterned after the legislation which created the very successful Geriatric Research, Education, and Clinical Centers [GRECC's], section 302 of Public Law 96–330, enacted in 1980. The MIRECC's would be designed first, to congregate at one facility clinicians and research investigators with a clear and precise clinical research mission, such as PTSD, schizophrenia, or drug abuse and alcohol abuse; second, to provide training and educational opportunities for students and residents in psychiatry, psychology, nursing, social work, and other professions which treat individuals with mental illness; and third, to develop new models of effective care and treatment for veterans with mental illnesses, especially those with service-connected conditions.

The establishment of MIRECC's should encourage research into outcomes of various types of treatment for mental illnesses, an aspect of mental illness research which, to date, has not been fully pursued, either by VA or other researchers. This provision will promote the sharing of information regarding all aspects of MIRECC's activities throughout the Veterans Health Administration by requiring the Under Secretary for Health to develop continuing education programs at regional medical education centers.

Madam President, the VA for too long has made inadequate efforts to improve research and treatment of mentally ill veterans and to foster educational activities designed to improve the capabilities of VA mental health professionals. The establishment of MIRECC's will be a significant step forward in improving care for some of our neediest veterans. I am hopeful that this long recognized need will become more than a forgotten want item for veterans who suffer, in many cases, in silence.

HOSPICE CARE

Madam President, I am pleased that the compromise agreement includes a provision, section 341, which directs VA to carry out a research study on the desirability of VA furnishing hospice care services to terminally ill veterans and the most cost effective and efficient way to furnish such services. This provision is derived from legislation I authored which was included in S. 1359 as considered by the Senate committee. That legislation was in turn based on legislation dating back to the 102d Congress.

Madam President, I have been pursuing an effort for a number of years to have VA closely examine the area of hospice care so as to have a basis for deciding the Department's role in meeting the needs of terminally ill veterans.

In my view, it is important that VA develop the most cost-effective methods of providing treatment to those groups of veterans, especially those older veterans, who are most likely to seek VA services in the coming years. Among the methods that can meet the needs of an older population are a wide variety of community-based, noninstitutional services, including hospice care, which provides a compassionate alternative to customary curative care for terminally ill persons.

During the Veterans' Affairs Committee's pursuit of this issue, there have been a number of hearings and submission of reports by VA. While the record before the committee on hospice care, including hearings in 1991, 1993, and 1995, indicates that there is some focus on hospice care within VA, I am convinced that VA has moved ahead too cautiously to establish programs which achieve the goals of hospice care. For example, while VA, on April 30, 1992, issued a directive that required all VA medical centers [VAMC's] to implement hospice programs, that directive provided only vague guidelines, regarding the manner in which VAMC's should provide hospice care. As a result, significant variations now exist in the manner in which hospice care is provided at VAMC's.

VA reports that all VA medical centers now have hospice consultation teams, consisting of at least a physician, nurse, social worker, and chaplain, and 56 out of 171 VAMC's have inpatient hospice units, freestanding buildings or separate units where a home-like atmosphere is created.

While this is an increase in the total number of inpatient units in recent years, it is not clear that it demonstrates a significant change in the overall effort in support of hospice care. In answer to posthearing questions on its hospice programs, VA noted that ''most VA inpatient hospice units are small with an average size of 7 beds.'' Other VAMC's provide pain management and other services to terminally ill veterans in units in which hospice rooms are adjacent to rooms in which other patients are administered

curative care. Still other VAMC's only provide some hospice services such as caregiver counseling and pain management.

Unfortunately, many VAMC's hospice efforts offer only an assessment of a terminally ill veteran's needs and referral to a non-VA hospice. While such referrals may benefit some veterans, they are of little value to the many veterans who are not entitled to Medicare or Medicaid or lack health insurance coverage for hospice care. Because VA has no authority under current law to contract with non-VA hospices, these veterans are left with the difficult choice of foregoing hospice care or using their own resources to pay for that care.

Although I am convinced that VA should provide hospice care, I am not certain as to the best way for the Department to provide such care. Some assert that the only bona fide form of hospice care is through a program in which palliative care—noncurative care focusing on alleviating pain and other symptoms—and support services to meet the psychological, social, and spiritual needs of patients and their families are available in both home and inpatient settings. Others believe that equally effective care can be furnished by integrating hospice concepts into customary care. Similarly, there is considerable disagreement as to whether veterans who wish to receive hospice care are best served by VA hospice programs or through contracts with non-VA providers.

Because I am satisfied that VA, to this point, has not carried out sufficient research to determine with any degree of certainty the most appropriate way in which to furnish hospice care, I have proposed legislation that would require VA to study the ways in which hospice care can successfully be furnished to veterans. That is what the provision in the compromise agreement calls for, and I look forward to VA's efforts to carry out this research and to the results of that study.

Given the growing numbers of VA patients who are elderly or have fatal diseases who could benefit from hospice care, demand for VA hospice care is likely to increase. Research related to the provision of hospice care is critical not only to VA health care professionals, many of whose patients cannot rely on friends and family to provide all of the care they require, but also to other health care providers who will soon have to accommodate a great increase in the number of aging patients comparable to that which VA is presently providing care.

MAMMOGRAPHY QUALITY STANDARDS

Madam President, I am delighted that the compromise agreement includes a provision, section 321, which seeks to ensure that women veterans are guaranteed that they will receive safe and accurate mammograms from or through VA. This provision is derived from legislation, S. 548, which I introduced last year.

At present, under the Mammography Quality Standards Act of 1992, Public Law 102–539, all health care facilities—hospitals, outpatient departments, clinics, physicians' offices, or mobile units—are required to be certified by the Secretary of Health and Human Services as meeting specified standards for mammography in equipment, personnel, and quality assurance. That law, however, does not apply to VA facilities that operate their own mammography equipment.

It is my strong opinion that women veterans who use VA facilities should have the same assurances as other women that their mammography tests will be performed properly and yield reliable information. The Secretary of Veterans Affairs agrees. In a letter to me, dated July 12, 1993, Secretary Jesse Brown wrote, ''It is my intent that VA will comply with standards equal to those set forth in the Mammography Quality Standards of 1992 for all mammography done within VA facilities and require that all contracts and sharing agreements for mammography include a provision for compliance.''

More recently, at the committee's October 25, 1995, hearing, Dr. Kenneth Kizer, VA's Under Secretary for Health, updated Secretary Brown's commitment, noting that ''VA policy now requires compliance with the requirements of the 1992 Mammography Quality Standards Act. Moreover, all VA facilities furnishing mammography services are currently using the FDA's guidelines.''

Section 321 of the compromise agreement would ensure that the goal of giving women veterans safe and accurate mammograms continues to be met by requiring the Secretary to promulgate quality assurance and quality control regulations for VA facilities that furnish mammography that are no less stringent than the Department of Health and Human Services regulations to which other mammography providers are subject under the Mammography Quality Standards Act of 1992. VA facilities that contract with non-VA facilities would be required to contract only with facilities that comply with that act.

OUTSIDE EMPLOYMENT

Madam President, I am pleased that the compromise agreement includes a provision, section 347, relating to the limitation in current law on certain VA health care personnel's ability to work outside of VA—the so-called ''moonlighting'' bar. Under current law, full-time VA professionals in seven professions—physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries—are not permitted to work in their professions during their non-duty times at VA.

This provision was reported by our committee in S. 1359 after it was amended in committee in response to a concern of mine. As originally introduced in S. 1752, VA-proposed legislation, the legislation lifted the bar to outside work for only three of the seven professions listed in current law. In response to my concerns, the provisions removed the existing limitation as to all seven of the title 38 professions, including physicians, and not just to a portion of that population.

CONCLUSION

Madam President, in closing, I acknowledge the work of my colleagues in the House, Chairman BOB STUMP and the ranking minority member, SONNY MONTGOMERY, and our committee's chairman, Senator SIMPSON, in developing the comprehensive legislation.

Madam President, I thank the staff who have worked extremely long and hard on this compromise—Ralph Ibson, Lori Fertal, Pat Ryan, JoAnn Webb, Sloan Rappoport, and others on the House Committee, and Bill Brew, Jim Gottlieb, Bill Tuerk, Chris Yoder, and Tom Harvey with the Senate committee. I also thank Bob Cover and Charlie Armstrong of the House and Senate Offices of Legislative Counsel for their excellent assistance and support in drafting the compromise agreement.

Mr. NICKLES. Madam President, I ask unanimous consent that the amendment be agreed to, the bill be deemed read a third time and passed, the amendment to the title be agreed to, the motion to reconsider be laid upon the table, and that any statements relating to the bill appear at the appropriate place in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 5414) was agreed to.

The bill (H.R. 3118), as amended, was deemed read a third time and passed.

The title was amended so as to read: ''An act to amend title 38, United States Code, to reform eligibility for health care provided by the Department of Veterans Affairs, to authorize major medical facility construction projects for the Department, to improve administration of health care by the Department, and for other purposes.''

HONG KONG ECONOMIC AND TRADE OFFICES LEGISLATION

Mr. NICKLES. Madam President, I ask unanimous consent that the Senate proceed to the immediate consideration of Calendar No. 628, Senate bill 2130.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

A bill (S. 2130) to expand privileges, exemption, and immunities to Hong Kong Economic and Trade Office.

The PRESIDING OFFICER. Is there objection to the immediate consideration of the bill?

There being no objection, the Senate proceeded to consider the bill.